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EXECUTIVE SUMMARY

One of the nine characteristics enumerated in the Consensus Statement on Quality in Public Health is that the system should be “efficient—understanding the costs and benefits of public health interventions and to facilitate the optimal utilization of resources to achieve desired outcomes.”

This report addresses the trade-offs of decentralized, centralized, and shared or regionalized public health systems; the history of public health funding and governance in Washington state; examples of the organizational structure and creative public health funding mechanisms in states outside of Washington state; and, includes key points on what the future has in store for local public health funding.

Washington state has an interesting and winding public health financing history. Policymakers and community members alike have strongly supported and voiced their belief in the invaluable role of public health. However, as this report outlines, the funding streams have not always followed the community's value regarding public health. Public health is a unique and quiet public service; when it is operating at an optimal level, most people are unaware of its existence. This understated nature creates a climate of uncertainty related to funding for public health; significant revenue streams are not guaranteed and generally follow a major emergency (e.g., funds for bioterrorism threats in the wake of September 11, 2001).

Many states and localities across the United States, including Public Health – Seattle & King County, have become increasingly eager to “fix” the public health system for good. Specifically, there is overwhelming interest in public health governance, and in developing mechanisms for sustainably financing public health at the state and local level. This report is intended to inform and inspire public health leaders, policymakers, and community members to: 1) Design a financially sound public health system, complete with collaboration; and, 2) Fund all local health jurisdictions in an equitable, sustainable, and sufficient manner.
INTRODUCTION

Public health is designed to “protect and improve the health of communities by preventing disease and injury, reducing health hazards, preparing for disasters, and promoting healthy lifestyles.” What distinguishes public health from health care is public health’s focus on prevention within populations, rather than treatment of individuals. In 2008, Washington’s Public Health Improvement Partnership identified the following five key aspects of public health:

1. **Understanding health issues** through data collection and analysis;

2. **Protecting people from disease** through disease surveillance, case investigation and control measures;

3. **Assuring a safe, healthy environment for people** through food, water, waste and other regulation for safety;

4. **Promoting healthy living** through locally-focused health promotion activities; and,

5. **Helping people get the services they need** through assessment, referrals, and some direct services.

From the perspective of the health and wellbeing of a population, public health is undoubtedly an asset. However, increased pressure has been placed on public health in recent decades to prove its financial benefit (e.g., return on investment) to the community. Further complicating the matter is the unique position public health is in: When public health is functioning at an optimal level, people generally do not notice it exists.

In Washington state, similar to what is being observed across the country, “the national economic crisis is taking a severe toll on public health agency budgets...causing already-strapped agencies to operate with significant workforce reductions.” Washington state’s local health jurisdictions (LHJs) face reductions in county revenue due to “declining county incomes from property and real estate excise taxes and sales tax.” In addition, the Washington State Legislature is “coping with an unprecedented revenue shortfall due to a precipitous decline in sales tax revenue.” On the federal level, reductions are occurring in revenues that support state and local public health efforts.

<table>
<thead>
<tr>
<th>COST OF OBESITY</th>
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<tbody>
<tr>
<td>“Obesity—increasingly a focus of public health programs—is associated with such costly conditions as diabetes, heart disease, arthritis and complications during pregnancy.”</td>
</tr>
<tr>
<td><strong>Price tag:</strong> Adult obesity costs the country between $147-$168 billion in increased medical expenditures.</td>
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To further complicate matters, public health funding from the state and federal level, has come, at least in part, in the form of categorical funds (e.g., funds earmarked for a specific service, program, disease, etc.). This reliance on categorical funds often proves problematic for many local health jurisdictions (LHJs). For instance, California’s LHJs have suffered as a result of inflexible funds:

"[California’s] process for administration and funding at the local level is fragmented, inflexible, and fails to hold local health jurisdictions (LHJs) accountable for achieving results. This reduces the effectiveness of these programs because these services are not coordinated or integrated and LHJs cannot focus on meeting the overall goal of improving the public’s health."\(^5\)

While categorical funds can help maintain some important, longstanding public health services, there is a distinct need for increased levels of flexible funds directed to LHJs. Specifically, flexible funding for innovation, experimentation, and building the evidence base, is necessary to combat what is killing people today (e.g., chronic diseases).

Chronic disease has been identified as the “largest and fastest growing share of both public and private health expenditures, accounting for more than 75 percent of U.S. health care costs.”\(^2\) While most of these costly chronic diseases are preventable, less than five percent of health care spending is currently allocated to public health efforts (see Figure 1).\(^2,6\)

**Figure 1.** Comparison funding for disease prevention with premature deaths, King County, WA, 2009.
Public Health – Seattle & King County has become increasingly interested in creative, new approaches to sustainable local public health funding streams. Before jumping into the details of public health organizational structure and financing, it is important to first build the case for why fully funding public health is in the best interest of the population. Fortunately, there is a growing body of research on public health financing, which “indicates an increased understanding of the financial and economic aspects of public health.” Specifically, there are the three core question public health departments are asking related to financing:

1. Does funding improve the performance of core public health functions?

2. What is the relationship between funding, spending, and improved public health outcomes?

3. What are the tools and techniques used to demonstrate these links?

Public health finance research strongly supports the association between increased spending by LHJs and increased performance; one study found that “higher spending per employee was associated with higher performance on 9 out of 10 Essential [Public Health] Services.” Applying this research locally, a Washington state project found that larger LHJ budgets are connected to higher performance scores in the National Public Health Performance Standards Program (NPH-PSP).

However, looking at the 10 Essential Public Health Services (listed to the right) developed in 1994 by the United States Core Public Health Functions Steering Committee, public health essentially does everything. As Public Health – Seattle & King County (PHSKC) Director and Health Officer, David Fleming, MD, noted, almost anything a public health department might want to do could fit under this list (April, 2013). State and local public health leaders have recognized a need to narrow public health’s focus. To that end, the Washington State Department of Health and local public health directors have collaborated on a new project called the Agenda for Change. This initiative seeks to answer the question: What are the foundational services every health department must provide?

---

**ESSENTIAL PUBLIC HEALTH SERVICES**

1. **Monitor** health status to identify and solve community health problems.
2. **Diagnose and investigate** health problems and health hazards in the community.
3. **Inform, educate, and empower** people about health issues.
4. **Mobilize** community partnerships and action to identify and solve health problems.
5. **Develop policies and plans** that support individual and community health efforts.
6. **Enforce** laws and regulations that protect health and ensure safety.
7. **Link** people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. **Ensure** competent public and personal health care workforces.
9. **Evaluate** effectiveness, accessibility, and quality of personal and population-based health services.
10. **Research** for new insights and innovative solutions.

---
Similarly, according to David Fleming, MD, PHSKC has adopted a framework known as the “3Ps” (see description to the left) to describe its role in the Seattle and King County communities in a more simple and concise manner than the 10 Essential Public Health Services (April, 2013).

Furthermore, while public health finance research clearly points toward an association between spending and performance, when it comes to a connection between spending and health outcomes, little evidence exists. The reason for this is that public health is simply a player in the larger health system, and thus it becomes difficult to parse out which segment of the system is responsible for influencing health outcomes. Regardless of the evidence base, public health generally argues that it is responsible for the health of the population in the hours spent outside of the doctor’s office—or the majority of the time (see graph to the right).^9

Several studies have attempted to build the connection between increased public health spending and improved population health outcomes. Findings from two of these key studies include:^7

1. **Erwin et al** found that increased public health department spending from 1997 to 2005 was associated with decreases in state-level infectious disease morbidity;^10 and,

2. **Mays & Smith** found that increased LHJ spending from 1993 to 2005 was significantly associated with decreases in mortality rates from four causes (influenza, cancer, heart disease, and diabetes).^11

Understandably, finances alone will not fix all health problems in a community. However, sustained and adequate funding for LHJs is a crucial component of the solution.
Specific aims

- Develop a comprehensive understanding of the funding structures of the public health system in King County, including the interconnections and partnerships involved, and how the governance structure related to financing.

- Explore alternative ways to fund public health and make policy recommendations.

Community benefit of this paper

Since the primary focus of this paper is through the lens of Public Health – Seattle & King County (PHSKC), the specific community being served is the more than two million diverse King County residents. The mission of PHSKC is to “identify and promote the conditions under which all people can live within healthy communities and can achieve optimum health.” That said, because a large component of this paper examines funding allocated at the state level to local health jurisdictions (LHJs), findings may also benefit LHJs in outside of Public Health – Seattle & King County.

Problem statement

Identify inefficiencies in local public health governance and financing in King County, by examining the local history, and researching best practices from other localities. Specifically, Public Health – Seattle & King County (PHSKC) has identified a gap in existing information on how local health jurisdictions across the country are funded. There is accessible information on federal level funds that reach the state level, but not a comprehensive analysis of state general funds allocated to local health jurisdictions. Through a process of surveying other states, PHSKC hopes to gain insight into how to improve the public health funding structure in Washington state. The end goal is to research emerging funding mechanisms, and then discuss with local public health leaders and policymakers options that may be feasible in Washington state.

Local background

The trend over recent decades, across the county, has been to gut public health funding. While cuts have occurred to public health at all levels in the United States, local health jurisdictions (LHJs) have been among those hardest hit. PHSKC is no different than any other LHJ in the country in terms of extensive funding reductions and the elimination of key programs.

To further complicate matters, the Great Recession
has taken a big toll on public revenue in the United States. Washington state's response has been to reduce services, but not to raise revenue, which has resulted in $10.5 billion in state general fund cuts from 2009-2012 (Figure 2).

Figure 2. Washington state budget cuts in $ millions, 2009-2012.

Methods

Description of approach and steps

- Literature review;
- Surveying of counties and states;
- Interviews with Washington state public health professionals to understand the history of public health funding and structure locally;
- Analysis of literature, and survey results; and,
- Writing of capstone report.

Description of data analysis/evaluation

Selection of study subjects

- **County information**: All counties were surveyed; and,
- **State information**: Began by connecting with states that have a similar population size and public health governance structure to Washington state.
Data collection

- **State survey**: Developed by Amber Bronnum;
- **County survey**: Developed by Jennifer Muhm; and
- **Interviews**: Developed by Amber Bronnum and conducted only with states and county representatives who needed additional information to answer their respective survey. Interviews were also conducted with public health professionals to supplement and/or provide anecdotal information on specific subjects.

Data analysis

Once the survey data was compiled, information from counties and states was compared to data from King County and Washington state, respectively, to determine any large discrepancies. Following the comparison, all data found in the process of the state and county surveys were compiled, cleaned, and placed in the report appendices. For the public health professional interviews, hard data cited were then fact-checked using available research before being incorporated in the report.

**UNITED STATES PUBLIC HEALTH GOVERNANCE**

**Historical context**

Throughout the twentieth century, public health governance in the United States shifted from a federal-focused to a more state-focused approach, and then to a more local-focused public health system, with the increased development of local health agencies. This movement is primarily attributed to the shift in focus from “controlling infectious diseases and environmental hazards in the first half of the twentieth century, to combating chronic diseases after 1950 and then to battling societal issues with social roots” more recently. As this shift has occurred, public health efforts have increasingly placed an emphasis on local solutions. According to an article published in 2002 by Health Affairs, from the early twentieth century to the end of the century, the number of local health units increased from only a handful to more than 3,000.

In the past few decades, “several state health departments moved out of umbrella human service agencies to become freestanding agencies, while several others moved from freestanding status into umbrella agencies or saw service provision programs removed and centralized in other agencies.” Additionally, at the local level, “health department closures
and consolidation raised concerns over lack of coverage and an eroding local public health infrastructure.”

In reaction to the historic context and funding climates at the state level, state health departments across the county have organized their public health governance in one of the following four manners:

1. Centralized/partially centralized
2. Decentralized/partially decentralized
3. Mixed
4. Shared or regionalized

An overview of each of these governance mechanisms; examples of states with each of these structures; and, an illustration of which states in the United States fit into what category is below (Figure 3).

**Figure 3. State and local health department governance classification system.**

Centralized

Overview

A state’s public health system is deemed centralized when 75 percent or more of the:

“State’s population is served by local health units that are led by employees of the state and the state retains authority over many decisions relating to the budget, public health orders, and the selection of local health official.”

Strengths:

- The centralized nature of the funding provides financial stability for small and/or rural LHJs.
- Some LHJs in centralized states believe that “expertise resides at the state level especially with regard to control of outbreak management.”
- Centralization is often thought to be desirable when a comprehensive perspective is required to execute tasks.
- Centralization might minimize coordination problems: using emergency preparedness as an example, the central direction of resources and staff, for instance, might speed the process of mobilizing staff for a large-scale response by avoiding the need to negotiate agreements between state and local authorities.

Limitations:

- Since funding for local public health work comes from the state, “centralized governance may result in a more bureaucratic approach.”
- In centralized states, conflict may be related primarily to a lack of autonomy among local health officials: local health officials must have the basic skills to screen, triage, and know when they need additional assistance. Centralized states have the potential of struggling with this issue.
- Centralizing short-funded systems can result in higher-ups making local funding decisions based off of political calculations rather than need (Don Sloma, Director, Thurston County Public Health and Social Services, Oral Communication, February, 2013).
State examples

**ALABAMA – Largely centralized**

<table>
<thead>
<tr>
<th>Centralized:</th>
<th>Decentralized:</th>
</tr>
</thead>
<tbody>
<tr>
<td>65 local health units led by state employee, serving 77% of total state population. For these areas:</td>
<td>2 local health units led by local employee, serving 23% of total state population. For these areas:</td>
</tr>
<tr>
<td>• Budgetary authority rests with state government, but local government plays a non-binding advisory role</td>
<td>• Budgetary authority rests with local government with no state input</td>
</tr>
<tr>
<td>• Local governmental entities may:</td>
<td>• Local governmental entities may:</td>
</tr>
<tr>
<td>• Issue public health orders</td>
<td>• Establish taxes for public health</td>
</tr>
<tr>
<td>• Top executive is appointed and approved by the state</td>
<td>• Establish fees for services without state approval</td>
</tr>
<tr>
<td>• 0-25% of local health unit budget is provided by the state</td>
<td>• Issue public health orders</td>
</tr>
<tr>
<td></td>
<td>• Revenue from taxes/fees goes to local government</td>
</tr>
<tr>
<td></td>
<td>• Top executive is appointed by local officials but approved by the state</td>
</tr>
<tr>
<td></td>
<td>• 0-25% of local health unit budget is provided by the state</td>
</tr>
</tbody>
</table>


**Alabama strengths:**

- The centralized structure combined with regional health offices make it easier for the State Health Officer to directly influence the operations of various programs, such as maternal and child health.

- This structure allows for alignment of state priorities, values, and the mission of each program at the local level in an efficient manner. It also improves consistency in service delivery and policy setting, and allows for easier data collection at the local office level.

- The centralized structure with local offices allows for community-based service delivery and a strong local presence.

**Alabama limitations:** In part as the result of Alabama’s unique mix of centralization and regionalization, according to a 2004 report from the American Public Health Association, the state has experienced a sense of fragmentation. There are five regional health departments that at times are insular and there is a “lack of coordination of environmental
Public health services across [regional health offices], resulting in wasteful administrative costs, a duplication of efforts and in some cases omission of services.”

**Hawaii structure description:**

- Public health policy and budget decisions are made at the state level, although local public health officials are encouraged to implement policies in ways that are best suited for them.

- The majority of direct services are delivered through contracts with private sector health and human services organizations on each of the Hawaiian islands.

- Clinic based services are contracted with Community Health Centers.

- Placement of community resources at the “grassroots” level is an essential component in linking successful partnerships among policymakers, health care providers, families, the general public and others.

- Neighbor island coordinators and staff actively participate in both local and statewide coalitions and advisory groups which provides for open communication and recognition of varied cultural values and practices.
Hawaii strengths:

- Hawaii’s centralized structure allows for a focus on priority health needs statewide and activation of a unified approach in the provision of services.\(^{20}\)
- The procurement of direct services through contracting assures a continuity of service delivery throughout the entire state and allows the department d.\(^{20}\)
- Hawaii’s centralized system limits the number of competing agendas and priorities. State and counties alike have a common goal and purpose “to protect and improve the health and environment for all people in Hawaii.”\(^{20}\)

Hawaii limitation: While Hawaii’s centralized public health system has many strong qualities, the state’s geography compounds the sense of fragmentation sometimes experienced by centralized states.

Decentralized

Overview

In relation to all government services, decentralization is the process of moving administrative and fiscal authority from federal and state governments to local governments.\(^{22}\) This process is generally a result of political motives to move governing power to the local level.

The primary factors that influence how well a government (or public health system) performs when decentralized include the following:

- **Political framework:** One of the potential strengths of decentralization is the ability to bring the government closer to the people through a stronger electoral process that consists of citizen groups and direct community participation in the governing process. This increased community participation and localization of government is believed to lead to increased efficiency in how resources are allocated. However, in order to have this work properly, rules of how goods and services are delivered in a decentralized systems must be explicit and transparent.\(^{22}\)

- **Fiscal aspects:** Specifically, this component is referring to the distribution of authority to tax between the central and local government.\(^{22}\)

- **Transparency:** The ability for the public to access information on the actions and performance of government in a simple, timely fashion is crucial. Transparency
resulting in the public knowing what is going on, will in turn, empower the public to
demand effective government and the continuation of public services.\textsuperscript{22}

- **Citizen participation:** Decentralization, with the government closer to the people,
  has the ability to improve resource allocation and accountability—but this only
  happens in practice if the decentralized government understands and aims to
  improve life more than the central government.\textsuperscript{22,23}

- **Provide greater local and personal control** over the determinants of health.\textsuperscript{23}

- **Spur cooperative, intersectional action** among coalitions of stakeholders at the local
  level.\textsuperscript{23}

With the increase in decision-making power being absorbed by local communities,
“decentralized public health and health-planning systems place greater fiscal responsibility
for health on local governments and agencies.”\textsuperscript{23} As the United States has trended toward
more and more decentralization since the early 1960s, there has been a conscious effort to
balance the power by “leaving intact most of the highly centralized national, state, and
provincial taxation and corporate-financing mechanisms.”\textsuperscript{23}

One of the primary catalysts for decentralization in the United States was the Reagan
Administration’s significant increase in block grants in the 1980s.\textsuperscript{23} In 1981, “President
Reagan proposed consolidating 85 existing grants into seven block grants.”\textsuperscript{24} Following
President Reagan’s proposal, “Congress, as part of the Omnibus Budget Reconciliation Act
of 1981, consolidated 77 categorical grants into nine block grants.”\textsuperscript{24}

This increase in the establishment of block grants served as a catalyst for decentralization
because they were a method of taking federal funds and providing them (in the form of
blocks of funds) to state and local governments; in essence, bringing the money closer to
the people.

Additionally, decentralized public health systems give direct authority over the local health
department to local government, often (but not always) including a Board of Health. In
decentralized states, “local governments have direct authority over local health
departments, with or without a board of health.”\textsuperscript{18} Additionally, LHJ staff is “generally hired
at the local health department level; in some cases, they are hired at a regional level.”\textsuperscript{18}

Specific to funding, decentralized states require LHJs to work with county officials for
funding, which may “create greater opportunities or a greater need for LHJs to seek
collaborative arrangements to support funding.”\textsuperscript{17}
Strengths:

- **Improves the efficiency of resource allocation:** When resources are governed closer to the community, they will go towards most-needed services more often than if the resources are centralized. In addition, the closer the resources are to the community, the better the local governing force is able to respond to changes in supply and demand.\(^2^2\)

- **Promotes accountability and reduces corruption within government:** The closer the government is to the people, the lower the likelihood of corruption because the community is more aware of the actions of the government.\(^2^2\)

- Decentralized structures offer **greater flexibility** than centralized states in adapting to local circumstances.\(^1^8\)

- Decentralized states may have a **higher degree of autonomy** to hire staff and could more easily allocate funding according to local needs.\(^1^8\)

- In decentralized states, large cities do not need to rely as heavily on state assistance because resources are apportioned to address these issues, and local health departments are expected to be self-reliant in “home-rule” states, meaning states with a constitution that provides local governments with inherent powers.\(^1^8,^2^5\)

- **Improves cost-sharing:** The act of decentralization makes services provided by the government more responsive to demand and more transparent—essentially this means that households are willing to pay more (i.e., in the form of taxes) for services they perceive as matching their demand.\(^2^2\)

As a result of decentralization, LHJs have faced numerous challenges. In general, these local entities have struggles to manage the increased responsibility that comes with the shift away from centralization and towards decentralization. Some key limitations of decentralization specific to local public health are listed below.

Limitations:

- **Scarce resources:** Decentralization, in terms of local public health, is challenging because many communities simply “lack the local resources to resolve the complex problems they face and have limited control over outside influences. As a result, they have become increasingly beholden to external sources of support.”\(^2^3\)
Conflicting public priorities: Public health is sometimes in conflict with one of the main perceived strengths of decentralization: public participation. More specifically, “local public health and health-planning goals often conflict with each other and with the rights of individuals pursuing their own well-being and happiness.” A local example: local communities across the United States “facing decisions about whether to close or maintain hospitals often experience bitter and emotional debates that may generate a sense of disempowerment for many local groups and individuals.”

Conflicting priorities of state or federal and local governments: Issues may arise when a central funding source (i.e., the federal or state government) “requires a health-specific commitment, but the local population wishes to focus on a different problem that is not a priority for the central funding bodies.” For example, “a community group may receive funding from a research-oriented agency to examine health issues related to cardiovascular disease, while the community’s priorities may be focused on creating jobs and stimulating the local economy or dealing with a teenage drug problem.”

In decentralized states, funding for public health activities in small/rural communities may be problematic.

In states that have highly decentralized organizational structures, the need for some forms of coordination across levels of government may be particularly important.

Decentralized structures are feasible for those activities that are based on community specific needs that might not benefit from economies of scale.
State examples

MINNESOTA – Decentralized


Minnesota strengths:

- The Department of Health has a fair amount of policy authority, and it monitors health care costs and access to care. It was involved in access reforms in the state.26

- Generally good working relationships between the Commissioner of Health and other cabinet members, in part because the current governor has encouraged collaboration and programmatic work across organizational boundaries.26

- Governor created a sub-cabinet on health policy that involved agencies meeting regularly and attempting to coordinate their activities, which is reported to work well.26

- Strong collaborative working relationship between the State Community Health Services Advisory Board (SHCSAB) and the Commissioner of Health: resulted in strengthening the state/local relationship and has served as the basis for jointly planning major statewide initiatives.26

Minnesota limitation: The State Department of Health has influence over local health policy and agendas through its formula-based funding and categorical grants. There is current
concern about a lack of minimum standards for local health jurisdictions, and an interest in developing state/local performance standards.\textsuperscript{26}

Oregon strengths:

- High level of collaboration between the state and local public health.\textsuperscript{27}
- Oregon works to ensure local public health is involved in state-level discussions, which builds trust and ultimately strengthens the public health system.\textsuperscript{27}

Oregon limitations:

- Assessments of Oregon’s public health system in 2000 and 2002 showed substantial gaps, particularly in the prevention of infectious disease.\textsuperscript{27}
- Additionally, as is the case in many states, Oregon struggles with a historic lack of resources for local public health services.\textsuperscript{27}

Oregon 2013 legislative activity: HB 2348: Relating to regional public health authorities; creating new provisions.\textsuperscript{28} This bill establishes eight regional public health authorities, and transfers responsibility for public health services in each county to a regional public health authority.\textsuperscript{28}
Shared/largely shared

Overview

A state’s public health system is deemed “shared” when 75 percent or more of the state’s population is served by local health units; a shared system may be led by state or local government employees. If the LHJs are “led by state employees, the local government can make fiscal decisions, issue public health orders and/or select local health official.” In shared states where LHJs are led by local employees, the “state health agency retains authority over most decisions relating to budget, public health orders, and the selection of local health officials.”

State example

Florida structure description:

- Act as the foundation of the state’s public health care system, providing critical detection, treatment and prevention services that protect Floridians from disease and injury.
- County health departments (CHDs) are among the largest providers of clinical care in the state, providing more than 3.3 million visits to more than 1.0 million patients annually.
Florida strengths:

- Seamless integration of state and local policy development, with community health departments acting as the implementation arm of the state health department.  
- Statewide performance improvement process that uses shared measures across the state.

Florida 2012 legislative activity: Florida enacted HB 1263 in 2012, which revised the purpose and structure of the Department of Health by combining some of its divisions. The bill made substantive changes to Children’s Medical Services, tuberculosis control, onsite sewage, regulation of public bathing places, the nursing student loan forgiveness program, and the health professional licensure process. The original bill, as introduced in the House, would also have shifted major public health responsibilities to the counties. The proposed decentralized public health system would have funneled block grants to counties, which would have taken over duties and potentially staff from the state. Those provisions were not included in the bill as enacted.

Mixed

A mixed governance structure exists when there is a “combination of centralized, shared, and/or decentralized arrangements,” and no single governance type predominates. In terms of public health systems, in states with a mixed structure, local health services are provided by a combination of the “state agency, local government, boards of health, or health departments in other jurisdictions.”

Regionalized

In recent years, public health systems across the country have increasingly understood the limitations of a fully decentralized or centralized governance structure. In response, mixed and shared systems (described in the sections above) have surfaced. Additionally, regionalized (very similar to shared) public health structures have become more and more popular. In many communities across the country, the factors driving the current interest in regionalization include:

- Movement toward the use of objective performance standards both within a state and nationally, including the Public Health Accreditation Board’s (PHAB) voluntary accreditation effort.
- Local and state governments are experiencing significant fiscal challenges in the current economy. It is important to note that a policy and/or fiscal goal of achieving
economies of scale leading to lower costs do not necessarily lead to improved public health capacity and performance.

- **Priority attention** (often nationally driven) to a particular **programmatic area** has also been an impetus for more regionalization and cross jurisdictionally shared approaches to local public health service delivery.

Furthermore, the process of devising a regional strategy also motivates states to take a close look at current centralization or decentralization, and “examine which services would more appropriately be delegated to the regional structures and which would be best provided at the state or local level.”

The basic design of regionalization is to use a “variety of methods to identify and leverage or pool available resources within given geographic regions to enhance public health services at the state and local levels.” Regionalization varies by state. For example, some states use “federal dollars to establish intrastate regional structures, spending money to develop everything from shared training programs to new regional capacities, such as epidemiology offices.” Yet, other states have regionalized to create “standardized procedures to enable sharing of resources” and developing coordinated emergency response plans. Forms of regionalization include the following:

- A rural and sparsely populated county health department might use the environmental health expertise and capacity of its neighbor to ensure appropriate and timely service availability when it could not reasonably or efficiently develop and sustain the capacity by itself.

- Several county-based local health departments might selected a lead department, and apply for funding to address breast and cervical cancer needs across all the counties involved.

Further, researchers looking at the connection between regionalization and public health capacity or performance have arrived at the following conclusions:

- Regionalization does not necessarily result in improved public health performance and/or capacity.

- Collaborative sharing of services or capacities across jurisdictions is believed to improve performance and/or capacity.

- Sharing enables LHJs to ensure a particular service was available that it would not have been able to perform by itself by virtue of cost, available expertise, limited demand, etc.
In some instances, collaborative approaches serve to better assure more consistent and timely public health services and functions were provided throughout the participating jurisdictions, particularly in the area of public health preparedness response and communications.

**Strengths**

- Research suggests that public health services may be more “effectively and efficiently delivered on a regional basis, merging counties or states into geographic regions linked by similar health status, economic, or geographic characteristics.”

- The potential strengths of regionalization are especially apparent in small, less-affluent communities that lack the resources to meet all of their public health needs. Incorporating these communities into public health regions provides additional resources and “the potential to provide more services through economies of scale and scope.”

**Limitations**

There are two major limitations to public health regionalization:

1. **Politics**: As a result of regionalization, local political units may lose considerable control over resource allocation.

2. **Logistics**: Combining the proper local units into a larger, regional entity is a solvable, but complex, issue. Encouraging the development of informal, or organic, regional approaches may provide an attractive alternative to “top-down” regionalization.

**Approaches to regionalization**

- **Coordinating**: Occurs when local health departments work together deliberately to plan events such as training or exercises.

- **Standardizing**: Creates uniformity across individual health departments through mutual adoption of one another’s planning tools, press releases, and response procedures leading to interoperability, while all response functions remain under the operational control of the individual health departments in which they reside.

- **Centralizing**: Involves resources for planning or response that are brought together or controlled by a centralized entity. Regional preparedness is achieved by pooling resources to form a separate regional entity that would assume some functions of a regional public health agency during an emergency.
Networking: Involves building relationships to share information, can lead to coordination of efforts across jurisdictions, and may lead to better coordination during a crisis. It appears to be the most common approach to regionalization, especially in areas where regionalization is new.32

State examples

California

Health departments in the San Francisco Bay area “began working together in the 1990s to eliminate health inequities.”30 In 2002, these health departments formalized this regional collaboration, creating The Bay Area Regional Health Inequities Initiative (BARHII), which “represents eight San Francisco Bay area health departments and provides a strong example of regionalization in California.”30 In addition to the collaboration between the health departments, BARHII partners with the following:30

- Association of Bay Area Governments;
- Los Angeles Public Health Department;
- National Association of County and City Health Officials (NACCHO);
- Planning for Healthy Places, the Public Health Institute;
- Regional Asthma Management and Prevention;
- Shasta County Public Health Department; the Transportation;
- Land Use Coalition; and,
- Louisville, KY Center for Health Equity.

BARHII’s mission is “to transform public health practice for the purpose of eliminating health inequities using a broad spectrum of approaches that create healthy communities.”30 The Initiative is supported by a combination of funds from the California Endowment, the San Francisco Foundation, the Silicon Valley Community Foundation, the East Bay Community Foundation, and the Robert Wood Johnson Foundation.30 The standardized regional approach is believed to “add legitimacy to all departments’ efforts to address health inequities with their own county leadership.”30

Idaho

Idaho has a “regionalized, local health department system composed of seven multi-county District Health Departments, which collaborate at the state level with the Idaho Department of Health and Welfare.”33 The seven district health departments combined with the state health department effectively play “different but complementary roles in the planning, funding, delivery, and evaluation of health services in Idaho.”33 Furthermore, local “boards of health govern the seven autonomous multi-county district health departments.”33
Massachusetts

In 2002, the Massachusetts state health department established seven regions and 16 sub-regions. The primary catalyst for this regionalization effort was a worry that federal preparedness funds were spread too thin to be effective if all 351 separate and independent city and town health authorities received a share. The Massachusetts Department of Public Health funds a coordinator for each region and distributes money to each sub-region based on an agreed-upon scope of work.

FEDERAL PUBLIC HEALTH FINANCING

On a federal-level, the bulk of public health funding comes primarily from the Department of Health and Human Services (HHS), specifically through the Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), and the Centers for Medicare and Medicaid Services (CMS). Additional funding for public health programs is provided through a variety of federal agencies, such as the Environmental Protection Agency and the Department of Homeland Security. Federal funding for local public health services compose, on average, 50 to 85 percent of state budgets.

A notable increase in federal funding allocated to state and local public health departments occurred in the aftermath of September 11, 2001, as a result of bioterrorism-related legislation. In 2002, over one billion dollars annually was provided to state and local public health agencies (an annual federal funding increase of about 20 percent). While this funding source was welcomed by state and local public health, it is an inconsistent source of public health funding, doing nothing to provide a sense of financial stability to local public health.

Federal revenue categories:

- **Federal Funds:** Includes all federal grants, contracts and cooperative agreements, including WIC voucher dollars and Environmental Protection Agency (EPA). Excludes state Medicare and Medicaid programs for all eligible applicants and providers, State Children’s Health Insurance Program (SCHIP), mental health and substance abuse.

- **Medicare and Medicaid:** Medicare and Medicaid transfers or reimbursements for public health purposes or direct clinical services actually provided by health departments (e.g., nursing home inspections, lead testing, immunizations, outreach to Medicaid recipients, home health Medicare, and Elderly/Disabled Medicaid Waivers).

- **Other Sources:** Includes tobacco settlement funds, payment for direct clinical services (except Medicare and Medicaid), foundation and other private donations.
Common state revenue categories:16

- **State General Funds (GF-S in Washington):** Includes revenues received from state general funds to pay for state operations, which includes LHJs in Washington state. Excludes federal pass-through funds.

- **Fees and Fines:** Includes fines, regulatory fees, and laboratory fees.

- **Other State Funds:** Includes revenues received from the state that are not from the state general fund.

**Figure 4. State health agency revenue FY08 and FY09 by source of funding in millions (n=48)**

LOCAL HEALTH JURISDICTIONS (LHJs)

In Washington state, LHJs are local governmental agencies, independent from the state DOH, that carry out a wide variety of programs within the communities they serve. LHJs work closely with leadership at DOH, but do not report directly to DOH and only receive a small percentage of funding from the state.

WASHINGTON STATE GOVERNANCE

The Washington State Department of Health (DOH) was formed in 1989, as a result of the state’s desire to separate prevention efforts from the Department of Social and Health Services (DSHS) and to redefine the regulatory authority of the state Board of Health (Don Sloma, Director, Thurston County Public Health and...
Social Services. Oral Communication, February, 2013). DOH is led by the Secretary of Health, and works in partnership with Washington state’s relatively decentralized public health system, which includes “35 local health jurisdictions serving Washington’s 39 counties.”

LHJs in Washington state have long been financially supported by a “combination of local, state and federal funding.” However, the specific mix these funding sources and “the conditions attached to their use have changed significantly over time.”

Model: Decentralized

WASHINGTON STATE – Decentralized

Decentralized:
- 35 local health units led by local employee, serving 100% of total state population. For these areas:
  - Budgetary authority rests with local government with no state input
  - Local governmental entities may:
    - Establish fees for services without state approval
    - Issue public health orders
    - Revenue from fees goes to local government
    - Top executive is appointed and approved by local officials
  - 0-25% of local health unit budget is provided by the state

Source: Association of State and Territorial Health Officials (ASTHO), NORC at the University of Chicago. State Public Health Agency Classification: Understanding the Relationship Between State and Local Public Health. Arlington; 2012. Available at: http://www.norc..
**LHJ authority**: County/local governments

The local health officer, acting under the direction of the local board of health or under direction of the administrative officer is appointed under Revised Code of Washington (RCW) 70.05.040 or 70.05.035. In short, this RCW provides local health officers the authority to enforce state and local statutes and rules related to the public’s health; take necessary legal action to control the spread of dangerous, contagious or infectious diseases in their jurisdictions; and, inform the public on issues related to prevention, promotion and maintenance of health (see full RCW in Appendix A).

**Size of Washington’s public health system**

Washington state has 39 counties and 35 local governmental public health agencies, some of which are multi-county; they are separate jurisdictions, but highly dependent on, and approved by, County government (see Figure 8). LHJs in Washington state are independent from the State Department of Health, and are either “departments” or “districts.” The core difference, from a financing perspective, is that “departments” have county-level taxing authority, whereas “districts” do not have county-level taxing authority.
Figure 8. Local health departments/districts, Washington state.

Strengths

One of the primary strengths of Washington state’s public health system is a strong state agency with the core mission of improving population-based public health. Additionally, this agency benefits from strong collaborations with Washington’s 35 local health jurisdictions (LHJs). This combination of a strong state-level public health department and LHJs, has the potential to optimize the resources and efficiencies of the state department, and the local expertise and communities connections of the LHJs.

In 2004, the Journal of Public Health Management Practice published an assessment of Washington’s public health system, which focused on how the state’s LHJs measure performance. Through this assessment, strengths of Washington state’s system were identified, which are tied to investments that were made by the state from 1993-2003. These strengths include:

- Local capacity development funds, which have been used for focused efforts within LHJs;
- A focus on public involvement and community partnerships; and,

- A focus on developing assessment capacity and products within DOH and LHJs.

While this assessment found that Washington state LHJs are high performing, it was also found that “additional staff and resources will be required to bring the entire system to the best example level.” Specifically, variability was found among LHJs, which indicates that “performance, while connected to budget and size, also has other drivers.”

This assessment included quantitative, qualitative, and observational findings. In the end, the key takeaways of the study include the following system-wide improvement efforts:

- Develop strategies to increase revenue sources, including the involvement and funding from boards of health, and evaluate staffing ratios and skills assessment to address the needs for more appropriate resources.

- Develop, distribute, and implement standardized DOH processes for program planning, policies, and procedures, as well as consultation services between the state and local levels of the system. Provide standardized DOH templates for documentation of program goals and objectives, performance tracking and reporting, and quality improvement plans.

- Develop and implement system-wide standardization of measurement for key performance or outcome indicators and statewide databases.

- Increase system-wide knowledge and skills through education and training in quality improvement, program evaluation, and best practice tools and techniques.

**Limitations**

A primary challenge of Washington state’s public health system is that the DOH is “dwarfed in size and budget by the Department of Social and Health Services (DSHS) and the Health Care Authority (HCA).” This presents a challenge because “size” represents funding levels, indicating DSHA and HCA (the health care state agencies) receive significantly greater level of funding than DOH (the health and prevention agency). As is the case with most public services, levels of funding generally indicate levels of public investment (and perceived public value), causing one to deduce that Washington state, in general, values health care services more than prevention (or public health) services.

See more about the Washington State Public Health Service Standards, Improvement Plan, and Indicators in Appendix B.
Washington state health agency: Department of Health (DOH)

Prior to the formation of the Washington State Department of Health (DOH) in 1989, the state had a Division of Health, which was a component of a superagency, the Washington Department of Social and Health Services, from 1970 to 1989. Upon its creation in 1970, the Washington Department of Social and Health Services (DSHS) was designed to include the following state operations:

- Medicaid;
- Financial assistance;
- Nursing home affairs;
- Mental health;
- Developmental disabilities;
- Rehabilitation;
- Drug and alcohol;
- Juvenile and adult corrections;
- Licensure of facilities;
- Health planning; and,
- Public health.

Public health was not only last on the list for DSHS, but at the same time (early 1980s), Washington state earned the “dubious distinction of providing the lowest per capita state support to public health in the nation.” Responding to this, in 1985 a local health officer released a report detailing the ways in which the DSHS superagency was not working to address the public health needs of Washington state’s residents.

This report resulted in a bill introduced in the 1986 legislative session; the bill called for the “transfer of all personal and environmental health programs from DSHS to the new department [which would become DOH].” The bill passed with a supermajority in the Democratically-controlled Senate, but died in the House and was not viewed favorably by the Governor at the time, who worried the services of the new agency would overlap with DSHS, resulting in redundancies.

While the bill did not pass, according to Thomas Milne, published in the Journal of Public Health Policy, it served an extremely valuable function in highlighting to local health officials and policymakers that: 1) a number of problems existed with the management public health services under DSHS; and, 2) the Department of Ecology had “poor management practices, which were said to be negatively impacting the state’s environment.”

After two more attempts (in 1987 and 1988) to pass a bill calling for the formation of DOH, support from policymakers and public health officials was at an all-time high moving into the 1989 legislative session. The Governor was extremely supportive and drafted his own
version of the bill. After a long legislative battle, the bill passed and was signed by the Governor in 1989, resulting in the creation of DOH.  

Since the creation of the free-standing, independent DOH, it has served to help “Washingtonians live healthier lives by:”

- Empowering individuals and communities to make informed health choices;
- Assuring access to quality prevention and illness care;
- Protecting people from environmental threats to health; and,
- Advocating sound, cost-effective health policies.

**Board of Health**

As is illustrated in Figure 7 above, the Washington State Board of Health (BOH) is a separate agency from the Department of Health. The BOH has been in existence since Washington state was founded in 1889. The Washington State BOH is a nine-member body, appointed by the Governor, made up of:

- The Secretary of the Department of Health;
- 4 persons experienced in matters of health and sanitation;
- 1 person who is an elected city official who is a member of a local health board;
- 1 local health officer; and,
- 2 persons representing consumers of health care.

The BOH has “statutory authority and can make rules and regulations, particularly related to traditional public health areas such as communicable disease control and sanitation.” Since the formation of DOH in 1989, the authority of the BOH has significantly diminished. Currently, the BOH can “hear appeals in state and local rule enforcement, but rarely does.” The primary role of the BOH is to balance concerns of the state’s citizens with government enforcement.

**State-local collaborations**

**Public Health Improvement Partnership (PHIP)**

Washington state health reform laws passed in 1993 and 1995, recognized the “significant and distinct role” of public health, “requiring the Washington State Department of Health, in consultation with other partners, to develop a public health services improvement plan.” Additionally, the health reform laws included “budget provisos to appropriate new state general funds to be distributed to each local health jurisdiction;” these flexible funds later became known as Local Capacity Development Funds (see more on the history of LCDF later in the report).
Following the 1993 and 1995 laws, a portion of the LCDF funds (of about $225,000 per year) was allocated the establishment and functioning of PHIP, which was tasked with working on “system wide” public health improvements. In addition to the funding from LCDF, PHIP is supported, with funding and staff, by the State Department of Health. PHIP works to bridge the gap between state and local public health. PHIP is a “joint venture of state, local, and tribal public health entities in Washington.” PHIP also targets issues such as:

- Public health financing;
- Communication, quality improvement; and,
- Public health performance.

**Figure 9. Public Health Improvement Partnership (PHIP)**

Some of the primary products of PHIP include (also see **Figure 9**):

- **Standards**: Measures that evaluate the performance of Washington’s public health system.
- **Public health activities and services inventory**: The 2007 Legislature directed public health officials to identify a list of core public health activities and services delivered by the governmental public health system across the state.
- **Local public health indicators**: Local measurement of health status or determinants of health.

- **Agenda for Change**: In 2010, DOH Secretary Mary Selecky appointed the Reshaping Governmental Public Health work group to consider how the governmental public health system will transform over the next five years. The resulting document, An Agenda for Change, was based on a review of health data, public health system assessment, forces of change and identification of themes. It identifies three areas for the governmental public health system to most effectively improve the health of the public:
  - Communicable disease and other health threats;
  - Healthy communities and environments; and,
  - Public health partnering with the health care system.

The guiding principles of PHIP are as follows:

- We represent governmental public health (local, tribal, state and federal);
- Our vision is for a public health system that improves and protects the health of the people in Washington state;
- We know that health outcomes are improved through innovative strategies and evidence based public health interventions;
- We identify and respond to population-based health issues and trends;
- We value public health research to better inform our efforts;
- We acknowledge the importance of delivering results with the resources we have been given; and,
- We treat each other as valued colleagues and partners.

The PHIP works toward achieving its mission through work groups. Currently four work groups are each staffed by one representative of a local health department and one from DOH; work groups are tasked with tackling current PHIP initiatives, make recommendations, and/or create materials. Work groups focus on the following:

- Identification and inventory of public health activities and services;
- Implementation of the Washington Public Health Standards;
- Identification and review of public health indicators; and,
- Implementation of future strategies for governmental public health (called the Agenda for Change).

Connecting back to Public Health – Seattle & King County for a moment, Director and Health Officer David Fleming, MD, and Chief of Staff Dennis Worsham are actively involved in PHIP. Further, according to former PHIP workforce development member, Jack Thompson, the work of the Partnership has significantly changed since its conception: early
on, PHIP worked on assisting with increasing public health funds in the state, but more recently it has toned down its focus on public health financing due to the economic climate of the past few years (February, 2013).

Local Health Liaison, Office of Public Health Systems Development

To further bridge the gap between state and local public health, DOH’s Office of Public Health Systems Development employs a Local Health Liaison to serve as a communicator between LHJs and DOH. The Liaison “assists LHJs in navigating the state health system by serving as a point-person for questions, sharing resources and tools in response to requests, and coordinating other communication.” This Liaison is intended to be especially useful for small, rural LHJs that are not as experienced with navigating DOH. The Liaison communicates messages from DOH to the LHJs, specifically messages from the Secretary of Health. Additionally, the Liaison and the Secretary of Health hold “meet me” calls with LHJs in response to public health issues such as state budget announcements, vaccine shortages, natural disasters, or other issues that impact public health.

Washington State Association of Local Public Health Officials (WSALPHO)

WSALPHO serves as a “common voice” for the 35 LHJs in Washington state, providing a venue for local public health systems to collaborate. WSALPHO is an affiliate of the Washington State Association of Counties, ensuring the public health voice is represented through the association. Specifically, WSALPHO provides a forum for LHJs to “discuss, for example, funding and policy issues, or to formulate advocacy plans.” On the state level, WSALPHO connects with DOH frequently through “quarterly meetings that include the Secretary of Health, the Local Health Liaison, and other DOH staff.” For more information on WSALPHO, refer to Appendix C for WSALPHO’s 2011-2015 Strategic Plan.

WASHINGTON STATE PUBLIC HEALTH FINANCING

Primary state-level funding streams for LHJs

Historically, public health funding allocated by the Washington State Legislature has come in one or a combination of the following sources (see Table 1 for additional historical context):
1. **Millage Property Levy** – established in 1930s; repealed in 1976
2. **Motor Vehicle Excise Tax (MVET)** – established in 1993
3. **Local Capacity Fund Development (LCFD)** – established in 1993
4. **Blue Ribbon Public Health Fund** (5930) – established in 2007

See Appendix D for the 2011 breakdown of MVET, LCFD, and 5930 funds, by LHJ.

### Table 1. History of WA public health funding.

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>1930s-1970s</td>
<td>- <strong>Millage property levy</strong>: Portion of the local property tax (county governments were obligated to spend 21.5 cents per $1,000 of local assessed valuation) was set aside for general public health and tuberculosis control—repealed by the state Legislature in the 1970s.</td>
</tr>
<tr>
<td>1970s-1992</td>
<td>- Over time, local governments made very different choices, and per capita public health spending came to vary widely.</td>
</tr>
</tbody>
</table>
| 1993      | - Health Services Act of 1993 passed: established **MVET** (approximately $50 million per biennium) and **LCDF** ($10 million per biennium) funding streams.  
            - **Motor Vehicle Excise Tax (MVET)** revenues (2.95%) dedicated to core public health funding.  |
| 1995      | - **LCDF** expanded to $16 million per biennium.  |
| 1999      | - Voters approve I-695 repealing **MVET**.  |
| 2000      | - Legislature upholds **MVET** repeal—about a $49M/biennium loss for local health jurisdictions.  |
| 2001      | - Legislature creates “**MVET Backfill**” account for Public Health—$48M/biennium  
            (NOTE: as of 2012, this special account has never received an increase, effectively diminishing in value with inflation and with increased population).  |
| 2005/2006 | - Legislature convenes Joint Select Committee on Public Health Finance to study public health funding; its report finds $315 shortfall in public health funding.  |
| 2007      | - Governor’s Blue Ribbon Commission on Health Care Costs and Access calls for investment in public health; Legislature creates new account “**Blue Ribbon Public Health Fund**” to support local public health—$20M/biennium.  |
| 2009      | - Legislature cuts “**Blue Ribbon Public Health Fund**”—$16M/biennium  |
| 2011      | - Legislature cuts “**Blue Ribbon Public Health Fund**”—$10M/biennium  |

**Millage property levy**

This levy began in the 1930s as the funding source for public health. At the time, and into the mid-1900s, this was a categorical fund specifically for tuberculosis (TB), when the
illness was more common, in addition to providing flexible funding for general public health efforts. Counties were required to levy in the following manner:

- 6-1/4 cents/$1,000 assessed valuation for TB hospitalization;
- 6-1/4 cents/$1,000 TB control; and,
- 9 cents/$1,000 for general public health services.

Earmarking was removed for several reasons:

- It did not relate program prioritization to available resources during the budgeting process (i.e., limited county commissioner discretion in establishing spending priorities);
- An informal 1975 survey of western Washington counties found that dedicated funds for TB hospitalization and control far exceeded the amount needed to meet identifiable TB needs; and,
- The amount collected in each jurisdiction was not directly related to need for services but rather based upon total assessed valuation of property—resulting in funding and service levels that were not necessarily proportionate to need.

Unfortunately, in 1976, the Washington Legislature “repealed the requirement that those funds be spent on public health, leaving the cities and counties to determine spending levels for public health.” As of January 1, 1977, these dedicated levies were still in place, but the funds collected were no longer dedicated to public health.

**Motor Vehicle Excise Tax (MVET): Repeal and backfill**

Unlike health reform legislation in other states, Washington state’s Health Services Act of 1993 (E2SSB 5304) changed public health governance at the local level, recognizing that “public health needed a stable funding base in order to accomplish its core functions.”

The act, which “became effective on July 1, 1995, removed cities from the statutory responsibility of providing public health services and rested it solely with the counties; counties became responsible for public health administration and for the expenses of public health.”

The method of securing this “stable funding base” for local public health was to replace the previous cost allocation formulas with a dedicated “2.95% of the Motor Vehicle Excise Tax (MVET).” A percentage of the MVET funding that was previously “distributed to cities and towns” was now “redirected to the county health departments based on population.”

However, in 1999, Tim Eyman created Initiative 695 to repeal MVET. Initiative 695 passed, translating into an approximately $10 million annual loss to Public Health – Seattle & King
County, on top of the loss of other "leveraged" funds (for example, reimbursements from Medicaid and federal Medicaid Administrative Match funding). In a turn of events, Initiative 695 was found to be unconstitutional by the Washington State Supreme Court. Nevertheless, the legislature “acceded to the wishes of the voters and repealed the motor vehicle excise tax (MVET), resulting in a loss of $100 million annually in revenues for local cities, including sales tax equalization and funding for criminal justice and for public health” (counties lost $49.7 million per year, and public health lost $24 million).

In response to the elimination of the MVET funding, the legislature and governor committed to replace $66.3 million of the lost MVET funding, nearly half ($33.2 million) was allocated to fund public health specifically, in the 2001-2003 budget. This commitment by the governor and legislature to replace the lost MVET funding for public health resulted in the state provision of MVET Backfill funding in the 2001-2003 and the 2003-2005 budgets. Although each year public health received “approximately the same amount it had in 1999, the amounts appropriated for cities and counties continually decreased.” For example, in 2002, cities received “approximately 44 percent of the amount they had lost and counties 49 percent.” Furthermore, the 2005 budget had only “$2 million for cities, two percent of their losses from the repeal of MVET, while the county share was $4 million or eight percent of their losses.”

Furthermore, as shown in Figure 10 below, there was considerable local variation from 1995-2004. Local tax support for Public Health – Seattle & King County decreased by about 30 percent, whereas local tax support for public health only decreased by about 5 percent in the other 34 LHJs.

Figure 10: Public health spending per resident from local tax sources (inflation-adjusted, 2004)

Variations in local tax support result from a combination of factors, including:\textsuperscript{42}

- Differences in local property, sales, and real estate excise tax bases;
- Varying local spending commitments, particularly for criminal justice, which is the largest area of expenditure for most counties. For example, in 2004, San Juan County spent 37\% of its general fund revenues on law and criminal justice services. By contrast, law and criminal justice services comprised 61\% of King County’s general fund revenues; and,
- Differing levels of demand on the local public health system, particularly in areas with large concentrations of low-income and immigrant populations (see Appendix E for King County population statistics).

In summary, variations in “local taxing capacity, local spending capacity, and perceived local needs limit the extent to which local options taxes can be relied upon to assure availability of a basic level of local public health services statewide.”\textsuperscript{42}

**Local Capacity Development Fund (LCDF)**

The 1993 Health Services Act directed the use of state general funds to establish the Local Capacity Development Fund (LCDF).\textsuperscript{4} The LCDF is intended to support needs and priorities determined at the local level. A few key financial milestones for LCDF include:\textsuperscript{4}

- **1993-1995 biennial budget**: Appropriated $10 million in what was characterized as a “down payment” toward an estimated need for $115 million a year for local public health.”
- **1995-1997 biennial budget**: The LCDF was increased to $16 million.
- **Post-1997**: No further legislative increases were made toward this fund, regardless of population growth and inflation, and during an economic downturn in 1999-2001, the fund was reduced by $700,000.
Figure 11. PUBLIC HEALTH SERVICES - Funding of All Local Health Jurisdictions by Revenue Source, 2011

Blue Ribbon Public Health Fund

In 2006, the Washington State Legislature established the Blue Ribbon Commission on Heath Care Costs and Access. The Commission was co-chaired by Governor Chris Gregoire and Senator Pat Thibaudeau, and including twelve other legislative and state agency leaders.49

The overarching goal of the Commission was to create a five-year plan for “substantially improving access to affordable health care for all Washingtonians.”49 After the initial round of meetings, the Commission came up with the following goals to be realized by 2012:49

- All Washingtonians will have access to health coverage that provides effective care by 2012, with all children having such coverage by 2010;
- Washington will be one of the top ten healthiest states in the nation;
- Population health indicators will be consistent across race, gender and income levels throughout the state;
- Increased use of evidence-based care brings better health outcomes and satisfaction to consumers; and,

- The rate of increase in total health care spending will be no more than the growth in personal income.

To meet the above goals, the Commission devised a set of recommendations, which are detailed in Appendix F. One recommendation worth highlighting for the purposes of this report is recommendation number 15:

**Strengthen the public health system:** the Commission recommends that the state, subject to appropriation, invest in public health funding strategies that are accountable for improved health outcomes, based on the recommendations of the Joint Select Committee on Public Health Financing.\(^{49}\)

The Blue Ribbon Commission’s public health recommendations built on the earlier work of the Washington State Legislature’s Joint Select Committee on Public Health Financing. Chaired by Representative Shay Shual-Berke, this committee met in 2005 and developed a set of priorities regarding how the state should invest in public health. These priorities included:\(^{50}\)

- **Public health services** should focus on core, priority services (see text box to the right) and maximize efficiency;

- **State funding:** Maintain current investment, and provide additional investment of $100 million/biennium; and,

- **Local funding:** Additional investment needed, and current funding must be maintained.

In an effort of address the above priorities, the following legislation was passed with funding during the 2007 legislative session:\(^{50}\)

- **Blue Ribbon Commission Bill and Budget Proviso:** Amended Public Health Improvement Plan Law (RCW 43.70.520 and 580)

- **Created the Blue Ribbon Public Health Fund and provided $20 million/biennium to local public health:** New work with increased performance expectations, with an emphasis on communicable disease, chronic disease and immunizations.
Current situation and future of a state-level funding for LHJs in Washington state

Nationally, the Great Recession has hit public health quite hard. A survey conducted in 2011 by the National Association of County and City Health Officials (NACCHO) found:

- Decrease of at least 40,000 public health workers nationwide from 2008 to 2011 (Table 2);
- 87% of the local public health agencies surveyed reported that they had lost staff from 2008 to 2011; and,
- 41% reported that they are operating under a current budget that is less than the previous year (Table 2).

Table 2. Estimated number of LHJ job losses (2008-2011) and job losses and additions (July-December, 2011).

<table>
<thead>
<tr>
<th>Job Losses (Layoffs and Attrition) (2008–2011)</th>
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<td>2008</td>
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<tr>
<th>Job Losses and Additions (July–December 2011)</th>
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<tr>
<td><strong>Losses</strong></td>
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<td>Layoffs</td>
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<tr>
<td><strong>Additions</strong></td>
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<td>New positions</td>
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<tr>
<td>Vacancies filled due to lift of hiring freeze</td>
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<tr>
<td>Total</td>
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</tbody>
</table>

In Washington state, similar to what has been observed across the county, LHJs “face reduced county revenue due to declining county incomes from property and real estate excise taxes and sales tax.” As a result Washington state LHJs have responded in recent years by “reducing budgets, laying off significant volumes of staff, and cutting programs.”

**Declining local revenue**

As a result of the Health Services Act of 1993, which established MVET and LCDF, the “mix of sources for public health funding has shifted” in the past decade, with a “greater share of funding now coming from the state level and a smaller share coming from local sources.” However, funding levels for LHJs in Washington state have not kept up with population trends (see **Figure 15**): Between 1993 and 2004, the amount of funding from local sources dropped from $82.7 million to $60.4 million, a decline of 27%.

See recent numbers from King County in **Figure 13**.
Reliance on categorical funds

To compound the decentralized nature of Washington state is the fact that “most of the funding for public health in Washington comes (from the federal and/or state level) with strings attached, in restricted, category-specific grants and revenues.” Categorical funds
have value, but when they comprise large amounts of the LHJ budgets, they can hinder the a LHJ’s ability to “provide ‘core’ public health services, such as detecting and preventing infectious disease, and assuring the cleanliness of food and drinking water.”³ Some specific challenges that can arise from categorical dollars include:

- Often “arrive in small amounts and are available only for very specific purposes—not for alleviating the underlying causes of public health problems.”³

- May provide indirect support to core services in some cases, but the benefit of such “spillover” capacity is limited and does not substitute for direct funding.³

- Categorical funds are not always reliable—especially at the federal level.³

**Increasing reliance on fees**

Locally, “categorical funds” look differently than they do at the state and federal levels. At the local level, these funds “come from license, permit and other fees.”³ By law, “fee revenue must only fund the service for which the fee was charged, and must not exceed the cost of the service.”³ As **Figure 15** illustrates, “license and fee revenues has provided an increasing share of local revenues for LHJs” in Washington state.³ What does this mean for LHJs? It means a “greater reliance on an especially inflexible form of funding.”³ In many Washington state LHJs, such as Seattle-King County and Thurston County, revenue from fees generated for environmental health services almost entirely cover the expenses for the program (i.e., the program is self-sustaining).

**Figure 15. Local Revenue Sources by Percent of Total Revenue (Excluding King County): 1993-2004.**

Local funding disparities

Since the 1970s, “large disparities have emerged in the levels of local funding provided to LHJs across the state—and, by extension, in the levels of service each can provide.”³ For
example, two Washington state LHJs received local government funding at $20-40 per resident in 2004, while nine other LHJs received less than $4 per resident.³ (See Figure 16)

Figure 16. Total Per Capita Local Government Contributions by LHJ in 2005 Dollars, 2004 (Excluding Seattle-King County).

For a glimpse into how Washington state compares to other states in terms of state-level funding support, please refer to Appendix G.
PUBLIC HEALTH – SEATTLE & KING COUNTY

Historical context

Table 3. History of the Public Health, Seattle & King County.\textsuperscript{53}

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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| 1890    | • The Board of Health was created by City Charter with authority to supervise the health and sanitation of the City of Seattle.  
          • The King County Board of Health was abolished in 1908.          |
| 1900    | • Seattle’s public health agency was established as the Department of Sanitation. |
| 1951    | • The department merged with the King County Department of Health.     |
| Pre-1981| • City of Seattle administered the department with the two jurisdictions providing funding in proportion to their populations.  
          • King County Board of Health re-established.                    |
| Post-1981| • Reorganization placed administrative control in the hands of the County while the City retained direct policy and funding control over the Seattle Services Division.  
            • Departmental records are managed by King County.              |


Primary local funding sources

Great variation exists between Public Health - Seattle & King County (PHSKC) and any other LHJs in Washington state.\textsuperscript{3} PHSKC is the largest health department in the state (larger than even the State DOH) and serves a larger, denser, and more diverse population that any other Washington state LHJ.\textsuperscript{3} Additionally, Seattle & King County has largest concentration of high-risk individuals in the state.\textsuperscript{3} Because of the unique nature of the population served and the national influence of PHSKC it “employs a different way of categorizing the funds it receives.”\textsuperscript{3} In 2004 for example, PHSKC expenditures totaled $185 million, or 53\% of total spending by all LHJs in the state.\textsuperscript{3}

Further, a 2006 public health financing study concluded:

“Large public health systems [such as Public Health – Seattle & King County] may be able to realize economies of scale in performing activities such as disease surveillance and health education by spreading the fixed costs of public health infrastructure over larger populations of beneficiaries and taxpayers.”\textsuperscript{7}
Today, PHSKC’s local funds come from a combination of the King County general fund, the City of Seattle, the Seattle Families and Education Levy, and the Vets & Human Services Levy. For example, Seattle’s Families and Education Levy fund School Based Health Centers, a program run through PHSKC—during the 2010-2011 school year more than $4 million was spent on school based health centers and school nurses.\textsuperscript{54} To see the exact breakdown of local funding sources for PHSKC, and to see how it compares to other LHJs in Washington state, refer to Appendix H and Appendix I.

2013 King County Budget Proviso: Accountable and Integrated Health and Human Services Motion 13768

In the past few decades, “several state health departments moved out of umbrella human service agencies to become freestanding agencies, while several others moved from freestanding status into umbrella agencies or saw service provision programs removed and centralized in other agencies.”\textsuperscript{15} In King County, a process is currently under way of to lay out a plan for better integrating Health and Human Services (HHS). This work falls under Motion 13768.

In short, Motion 13768 calls for the Executive, “in collaboration with a stakeholder panel and the departments of Public Health and Community and Human Services, to develop a plan for an accountable and integrated system of health, human services, and community based prevention for the county’s residents in need.”\textsuperscript{55} The need for King County’s HHS system to change is the catalyst for the King County Council calling for an integrated system. Key current concerns in King County’s HHS system include:\textsuperscript{55}

- Existing disparities result in negative impacts to citizens and drive up costs for all sectors: nonprofits, government, hospitals, emergency services, justice, etc.;

- The current provision of HHS involves multiple systems, funding streams, and reporting requirements without a single point of accountability;

- While some systems and some providers coordinate services, there is not widespread and organized systems integration and services alignment; and,

- Addressing disparities, improving health outcomes, and increasing efficiencies through an integrated system require expertise and collaboration.

The overarching goals of this work include:\textsuperscript{55,56}

- Creating a new integrated model that provides more effective, efficient services, and improved experience of health care and human services for residents;
 Addressing unnecessary duplication of services;

 Areas of lowered or controlled costs identified; and,

 Options for creation and implementation of a single point of accountability for HHS, quality and outcomes.

The panel working to integrate HHS is working on an assessment report that shall include:

1. Potential reorganization options, including an option for integrating the two departments into one department;

2. Summary of potential impacts of each potential reorganization option;

3. Summary of potential impacts to clients, providers, and the community; and,

4. Summary of potential impacts to federal and state contracts and revenue streams, including reporting requirements.

Additionally, plans for the integration implementation must include:

1. Identification of potential issues involved with the integration of the two departments and how issues will be managed or resolved, enabling integration to move forward;

2. List of King County Code changes to effectuate the integration of the two departments;

3. Schedule for integration of the two departments with milestones, timelines, and phases of integration; and,

4. Coordination with other county initiatives such as the health and human potential goal area of the county’s strategic plan.

Currently, King County in the process of conducting an assessment report and implementation plans “shall be on the integration of the department of community and human services and Public Health – Seattle & King County.” No decisions have been made on the assessment report yet; it is due to Council June 26, 2013.”
EMERGING PUBLIC HEALTH & PREVENTION FUNDING MECHANISMS

As is covered earlier in the report, public health has traditionally been funded by three sources: Federal, state and/or local funds. Historically, if one of these sources was experiencing trouble, the others could bolster and maintain the level of public health funding. However, the recent Great Recession significantly reduced all three of these sources at the same time. This traumatic experience has motivated public health leaders and policymakers across the country to think about developing and adopting creative and innovative methods of providing a dedicated revenue stream to public health.

New York State Medicaid Redesign Team (MRT) Waiver Amendment, 2011

"Reinvesting our state's savings to improve the Medicaid program can only help New Yorkers. Instead of Medicaid costing another $2.3 billion, in the 2011-12 fiscal year, savings initiatives are projected to save approximately $34 billion over the next five years, to be divided between the state and federal governments. Putting these funds back to work here in New York helps to keep New Yorkers healthier."  
- U.S. Representative Eliot Engel

Upon taking office in 2011, New York Governor Cuomo established, by Executive Order, the Medicaid Redesign Team (MRT). MRT was designed to bring together stakeholders and experts from throughout New York state to “work cooperatively to reform the system and reduce costs.”

Phase 1 of the MRT process consisted of providing a “blueprint for lowering Medicaid spending in State Fiscal Year 2011-2012 by $2.2 billion.” This phase was completed in February 2011, when MRT submitted its initial report, complete with recommendations on the redesign and restructuring of the state’s Medicaid program, to the New York State Legislature. Nearly all of the recommendations outlined in MRT’s report were approved by the Legislature and are currently in the process of being implemented.

Phase 2 of the MRT process consisted of the establishment of “10 work groups to address more complex issues, as well as [monitor] the implementation of key recommendations enacted in Phase 1.” MRT quickly recognized the need for a Medicaid waiver to fully implement its action plan, facilitate innovation, and lower health care costs. As a result, a Medicaid 1115 waiver amendment was submitted; the waiver, if approved will allow the state to invest some of the savings generated by MRT reforms to implement an action plan to transform the state’s health care system. Specifically, the waiver application requests that the federal government allow New York state to reinvest in its health care system over a five-year period, up to $10 billion of the $17.1 billion in federal savings generated by MRT reforms.
Further, MRT serves as a national model for how stakeholders can work together to develop a comprehensive reform agenda even during the most trying times. The waiver amendment’s broad objectives are consistent with the Centers for Medicare and Medicaid Services’ (CMS) Triple Aim:

1. Better health;
2. Better care; and,
3. Lower costs.

**Key strategies**

- Major investments to expand access to high quality primary care
- Grants to establish Health Homes to improve the quality of care for the state’s highest need/highest costs patients
- Expanding resources available to transform and protect safety net providers
- Positioning and preparing health care providers and consumers for long term care integration to managed care
- Innovations in public health strategies that will generate significant, long-term Medicaid savings

**Public Health Funding Mechanism**

According to Lucy Siegel at the New York Office of Health Insurance Programs, of the $10 billion New York State plans to reinvest over the next five years, “$395.3 million is earmarked for the following public health innovations” (December, 2012):

- Evidence-Based Preventive Nurse Home Visiting Services: $81.8 million
- Asthma Home-Based Self- Management Education and Environmental Assessments: $32.5 million
- Diabetes Prevention and Treatment: $200 million
- Home Visits to Promote Childhood Lead Poisoning Prevention and Treatment: $61 million
- Water Fluoridation to Promote Dental Health for Children on Medicaid and Quality Improvement Efforts to Address Health Care Acquired Infections and Prevent Sepsis: $20 million
Massachusetts Prevention & Wellness Trust Fund, Chapter 224, 2012

In August 2012, Massachusetts passed into law health care cost containment piece legislation with an emphasis on payment reform and innovation. This law created a Prevention & Wellness Trust Fund, modeled on the federal Prevention and Public Health Fund that was included in the Affordable Care Act. In addition to public health funds, this health care cost containment law:59

- Creates a Task Force on Behavioral Health Integration;
- Strengthens requirements for health plans to comply with mental health parity laws;
- Creates a new workplace wellness tax credit program to encourage businesses to implement qualified wellness programs;
- Creates a new Health Policy Commission that will develop standards for accountable care organizations, including the integration of public health interventions with an emphasis on social determinants of health; the promotion of community health workers; and, the integration of mental health and substance abuse services with primary care.

Prevention & Wellness Trust (the Trust) is a part of (Chapter 224) a broader law. The Trust will be financed at $60 million over four years. A minimum of 75 percent of the funds must be spent on competitive grants to the following:59

- Reduce rates of the state’s most costly preventable health conditions;
- Reduce health disparities;
- Increase healthy behaviors;
- Increase the adoption of workplace-based wellness programs; and,
- Develop a stronger evidence-base of effective prevention programs.

In addition, entities eligible for funding include:59

- Municipalities or regional collaborations of municipalities;
- Community organizations, health care providers, or health plans working in collaboration with one or more municipalities; and,
- Regional planning agencies.
Funding

The mechanism for financing The Trust will be a surcharge of less than one percent on Health Safety Net Surcharge Payers. Two-thirds of The Trust revenue will come from health insurers and one-third will come from large hospitals. Beginning the summer of 2013, the “Massachusetts Department of Public Health will distribute the funds, in consultation with the new Wellness and Prevention Advisory Board,” to the following recipients, all of which are required to partner with a local health department:60

- Local communities;
- Regional planning agencies; and,
- Health care providers.

The recipients listed above will “use grants from the Trust to carry our community-based prevention initiatives” that work towards the following aims:60

- Reducing rates of costly preventable health conditions;
- Lessening health disparities; and,
- Increasing healthy behaviors.

Management

Section 60 of the legislation requires the creation of a 20-member Trust and Advisory Board.59,60 The Trust will be administered by a Commissioner of Public Health, who will serve as the trustee. In addition, a Prevention and Wellness Advisory Board will be established to:59

- Make recommendations to the Commissioner concerning the administration and allocation of the Prevention and Wellness Trust; and,
- Establish evaluation criteria and perform any other functions specifically granted to it by law.

In the case that there are unexpended revenues in the Trust at the end of the fiscal year, these funds will not revert to the General Fund; instead the excess funds will be available for expenditure in the following fiscal year. All expenditures from the Trust shall support the state’s efforts to meet the health care cost growth benchmark.59
Evaluation

Under Section 276 of the law, there shall be a Commission on Prevention and Wellness which shall evaluate the effectiveness of the program. The commission is expected to be named in early 2013 and will include:

- State and local health officials;
- Experts in health equity, health economics, and public health research;
- Representatives from the health care and health insurance industries;
- The business community;
- Representatives of community health workers and public health nurses; and,
- Public health and consumer health associations.

The commission will conduct an evaluation by contracting with an outside organization with expertise in the analysis of health care financing. In conducting its evaluation, the outside organization shall, to the extent possible, obtain and use actual health plan data from the all-payer claims database as administered by the center for health information and analysis. The commission shall report the results of its investigation and its recommendations together with drafts of legislation necessary to carry out such recommendation to the:

- House Ways & Means Committee;
- Senate Ways & Means Committee; and,
- Joint Committee on Public Health.

The report will be posted on the state’s website no later than June 30, 2015.

Health Impact Bond (HIB)

The basic concept behind health impact bonds (HIBs) are that they provide a “market-based approach to pay for evidence-based interventions that reduce health care costs by improving social, environmental, and economic conditions essential to health.” The funding stream involved raising money from private investors to “invest in prevention interventions, capturing the health care cost-savings that result from the interventions, and then returning a portion of those savings to the investors as profit.”

The HIB concept is based off of a broader, more commonly recognized idea, the Social Impact Bond (SIB). For example, New York City is initiated a SIB to “reduce recidivism among juveniles in the justice system.”
Childhood asthma prevention, Fresno, CA

Fresno launched the first health care funding strategy in the United States to “both reduce treatment costs and provide a financial incentive to investors.” Fresno’s health care funding strategy has been termed a Health Impact Bond (HIB), and began in early 2013, with the aim of “reducing the incidence and severity of asthma, a condition that disproportionately affects low-income people and communities of color due to poor environmental conditions in communities and homes.”60,61 As background, here are some quick statistic about Fresno, which have helped form the focus of this HIB:60

- Fresno is the second-most impoverished and second-most polluted city in the U.S.
- Over 17 percent of Fresno residents have asthma, more than twice the national average.
- Every day in Fresno, 20 asthma sufferers go to the emergency department and three are hospitalized.

The bond will finance scientifically sound in-home interventions – interventions that both improve health outcomes and reduce health care costs.61 Specifically, these interventions consist of community health workers visiting the children’s homes to:

- Assess indoor triggers for asthma;
- Implement solutions that could include cleaning or replacing carpets;
- Monitor medication compliance;
- Suggest changes in behavior (i.e., not smoking around children); and,
- Remove dust, mold, and pests.

To better understand the financial case for Fresno’s HIB, researchers at the University of California Berkeley School of Public Health partnered with a health impact investing firm called Collective Health to study the “potential for reducing health care costs by investing in home-based remediation of environmental conditions in the homes of Fresno residents with severe asthma who are frequent users of emergency and hospital treatment.”60 They found that the HIB-funded intervention would “generate net savings of over $4.5 million and a return on investment of $1.69 for every dollar spent on the intervention.”

Assuming this intervention is successful, insurers will pay out “far less in health care reimbursements than they would have without the intervention.”61 Then, as a result of savings experienced by insurers, the bond issuers will then be repaid a portion of the savings realized by the insurers.61 See Figure 17 for an illustration of Fresno’s funding mechanism.
Whether or not the HIB concept can be applied to more complex illnesses outside of asthma, such as chronic illnesses such as diabetes, is unknown. That said, HIBs are being envisioned to “fund interventions that would reduce hospital admissions for acute conditions such as asthma, traffic injuries, or environmental poisonings, in which a reduction in health care costs and return on investment might be easily identified and attributed to the intervention.”

In the meantime, “because asthma is eminently preventable,” the Fresno HIB project is working to “find the most motivated partners” they can. This sense of urgency is what motives them to look to the free market to improve health outcomes while lower costs.

In conclusion, Fresno’s HIB experience led to the identification of the five components needed to create a successful investment opportunity:

- Target outcomes must be clearly defined and achievable;
- The proposed intervention should reflect best practices;
- Measuring outcomes must be independently validated;
- A clearly defined “savings” or return value should be established; and,
- Public agencies, nonprofits, investors and community stakeholders must all be willing to work together.

Privatization

For a variety of public services, local governments have chosen to either fully privatize services or to model some practices after the private sector. Examples of public-sector services incorporating market arrangements with private not-for-profit or for-profit organizations include:
- Contracting out services;
- Using single-bidder or multiple-bidder approaches; and,
- Establishing other partnerships.

Important considerations for achieving the “optimal degree of private responsibility” include:

- Economic considerations;
- Administrative and employee concerns;
- Practical challenges; and,
- Public acceptance.”

Focusing specifically on public health, it is especially important that criteria to “help public health professionals...determine the public sector’s role - what can be shifted to the private sector (through contracts or partnerships) and what must remain public.”

Beyond privatization of services are other approaches to incorporating private sector principles in public health systems. For instance, a “public entrepreneur” may prove beneficial in public health, by adapting an entrepreneurial mindset for public employees. A public entrepreneur is an individual who is “challenged to create innovative, efficient solutions to public health problems within the governmental structure.” While considering the “nature of public health functions, it seems highly unlikely that public health entrepreneurial activity will generate revenue,” the public entrepreneur concept can be a helpful tool in generating creative innovative ideas.

Examples of services that should remain in the public health sector are related to risk. These services should remain in the public sector to “ensure that there is adequate oversight and to minimize transaction costs related to contracting these services out.” Conversely, services that “involve routine and repeated events may well be shifted to the private sector and monitored by the local health department through computer-based systems.” See **Table 4** for a list of services that are recommended to be privatized versus those that should remain in the public sector.
Locally, Clark County Public Health decided to move services out of governmental public health and into community organizations (more of a public-private partnership than fully privatization). Additionally, Clark County is recognized for being a highly collaborative community, with a number of health and human service-related networks, coalitions, roundtables, and task forces. At the center of many of these collaborations is the Clark County Public Health Department.

For example, Clark County partners with “local corner stores in neighborhoods to sell healthy food” and “neighborhood associations and businesses in developing community gardens.” John Wiesman, former Director of Clark County Public Health and current Washington State Secretary of Health, stated “I think in our department we have as one of our central themes that we must build partnerships in order to build these healthier environments, and I think truly that’s where we need to head as a field if we aren’t already.”

In the end, policymakers have the final say over the level of privatization for public services. Policymakers need to “determine which functions must remain with the public health system and which might easily become private-sector responsibilities,” while being mindful of “distinguishing between contracting out individual tasks or services and the wholesale privatization of critical functions or services, because each of those approaches has implications for oversight and accountability.” In fact, the value of privatization and public-private partnerships is explicitly called out in the Affordable Care Act (ACA), where many traditional public health services are now being covered by Managed Care Organization under the Medicaid Expansion and Health Benefit Exchanges (read more about the ACA related to public health below).
Affordable Care Act

The Affordable Care Act (ACA) of 2010 offers possibilities and potential challenges for the future of public health in the United States. The ACA “raises the profile of public health generally and addresses specific public health issues—adding new funding, creating new entities to help set priorities, and encouraging innovation, especially for population health including chronic conditions.” Among the most promising components of the ACA, specific to public health, are 1) Medicaid Expansion, 2) Community Benefit, and 3) the Prevention & Public Health Fund.

Medicaid expansion
Medicaid Expansion, that is extending Medicaid to all low-income Americans under 138% Federal Poverty Level, is a core component of the ACA, and is directly connected to public health. Medicaid Expansion, in addition to progressive provisions in the commercial health insurance market, will serve to “raise public awareness of the value of clinical prevention and wellness and provide concrete rewards to practitioners who emphasize health promotion.” Furthermore, enhanced coverage will serve to reduce the “burden on public health programs,” many of which have historically provided needed services themselves.

Community benefit (ACA Section 9007 / IRS Schedule H)

Non-profit hospitals have historically provided charity care, defined as necessary hospital health care rendered to indigent persons, as a condition of tax exempt status at the federal-level, and as a condition of licensure at the state-level. In anticipation for Medicaid Expansion in 2014, hospitals are expected to provide reduced charity care as more people will have health coverage. Community Benefit (Section 9007 in the ACA) provides a way for hospitals to demonstrate their level of providing public benefit as a condition of being a charitable organization with non-profit tax status. As part of federal and state health reform, Community Benefit aims to improve the health of populations (one of the Triple Aims) by addressing the upstream causes of so much of our poor health.

The specific section of the ACA that addresses Community Benefit is Section 9007. The overarching goal of this section is to “foster transparency and facilitate government monitoring of tax-exempt hospitals’ compliance with their charitable obligations.” Historically tax-exempt hospitals have provided charitable contribution in a reactionary manner, “one that often involves high-cost treatment of preventable conditions in...”
emergency room and inpatient settings.”65 Charitable contributions have historically been aimed towards making up for losses experienced as a result of un-planned charity care and public pay short-falls.65

Section 9007 attempts to incentivize non-profit hospitals to maximize community value; “Provide benefits for more people at lower cost through strategic in-vestments that reduce the demand for medical care.”65 This goal is achieved by creating a more explicit process of recognizing the role of hospitals in community-based prevention and encouraging an “approach to charitable investment that builds population health capacity for hospitals and contributes to the achievement of targeted health outcomes in the community.”65

Even before the passage of the ACA, an increasing number of hospitals nation-wide, especially in King County, begun the process of “reduce the demand for treatment of preventable illnesses.”65 However, the new federal community benefit reporting requirements (found on Internal Revenue Service (IRS) form Schedule H) have served to reinforce this shift by emphasizing:65

- Quantitative evidence;
- Strategic investment; and,
- Engagement of diverse community stakeholders to leverage hospital resources.

The component of the section most relevant to public health is community engagement:

“The ACA requires that hospitals take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health (ACA §9007(a), 26 U.S.C. §501(r)(3)(B)(i)).”66

Section 9007 requires that a “hospital describe its process for consulting with persons representing the community’s interests, as well as how it takes the resulting input into account; and, directs the hospital to identify those consulted in the process.”66

This portion of the ACA presents a unique opportunity for non-profit hospitals in King County to partner with public health like never before (see more information on collaboration between the Washington State Hospital Association, Public Health – Seattle & King County, and King County hospitals below). In the current environment of constrained resources, non-profit hospitals and their community stakeholders “may benefit from hospital engagement of diverse stakeholders as full partners, not only in conducting community needs assessments, but also in the planning, implementation, and evaluation of evidence-based health improvement strategies.”65

Furthermore, a “key question is the degree and manner in which state governments will incorporate the reporting requirements of ACA Section 9007 into state and local law and policy.”65 Washington state has proactively incorporated the Community Benefit
component of the ACA into state statute. During Washington state’s 2012 legislative session, House Bill (HB) 2341 was introduced. The bill digest reads as follows:

“Builds upon requirements established in the federal patient protection and affordable care act to increase the quality of, and accountability for, community benefit activities by nonprofit hospitals operating in the state. Requires each hospital that is organized as, or affiliated with, a nonprofit entity or is operated by a public hospital district to submit a community health needs assessment to the department of health. Requires a nonprofit hospital to annually provide community benefits, including charity care, by complying with certain standards.”

HB 2341, which passed and is now written into law, aligns state law with the new federal requirement. It prioritizes population health by directing hospitals to focus their Community Benefit activities toward addressing the five leading causes of death as identified in their Community Health Needs Assessment. Beginning January 1, 2014, nonprofit and public hospital district hospitals across Washington state “must submit a community health needs assessment (community assessment) to the Department of Health (DOH)” every three years. In addition to meeting any federal IRS requirements, community assessments must include the following components:

- **Hospital reporting**: Description of the community served by the hospital, including both a geographic description and a description of the general population;

- **Engagement with public health**: Description of the prioritized health needs of the community and the method for determining those priorities, including the five most common causes of death, identified public health needs, ambulatory sensitive conditions, and social determinants of health;

- **Collaboration within communities**: Description of the existing health care facilities, health care providers, and other resources in the community;

- **Description of information**: Assessment information must come from recognized authorities and sources of data and comments from members of the community served by the hospital, including community members, nonprofit community-based organizations, persons with special knowledge of public health, tribal governments, and representatives or members of populations that are medically underserved, low-income, minority, or chronically ill; and,

- **Health impact**: Assessment of the impact of prior implementation strategies on the health status and outcomes of populations targeted by community benefit activities.
In 2012, the King County Board of Health passed a resolution supporting the work of King County hospitals to meet the new Community Benefit standards, and promoting collaboration in the “assessment of the health needs of King County communities and the development of strategies to improve community health.”

King County hospitals (see complete list of non-profit hospitals in text box to the right) have a “long history of working to advance the health of the communities they serve through the provision of ‘community benefits,’ and community programs or activities that promote health and healing as a response to identified community needs.” Examples of past “Community Benefit” work includes the provision of the following:

- Charity care;
- Community health education;
- Training and continuing medical education for community physicians;
- Free clinics for low-income individuals;
- Medical research;
- Disease prevention programs; and,
- Financial support of community building activities such as low-income housing, job development and violence prevention.

Additionally, the resolution acknowledges and encourages the collaborative efforts, which formally began in 2011 as a result of the passage of the ACA, between King County hospitals (all of which as non-profit), Washington State Hospital Association, and Public Health – Seattle & King County. This collaboration has resulted in the sharing of work around “Community Benefit and to develop strategies to work together in their assessment of community health needs.”

**Prevention & Public Health Fund (ACA §4002)**

The ACA recognized the importance of prevention and public health through the creation of the Prevention and Public Health Fund (ACA §4002), a “funding stream dedicated to public health and prevention activities.” The fund represents the “most substantial effort in many years to fund the public health infrastructure and support community-based public health and prevention work.” The creation of the fund, combined with the creation of the National Prevention, Health Promotion, and Public Health Council, is the “first time a comprehensive public health strategy with dedicated funding has been articulated in federal law.”
The fund was designed to “build on the approach taken in the American Recovery and Reinvestment Act of 2009, which provided $650 million for chronic disease prevention.” The Recovery and Reinvestment Act was reached local public health in the form of the two-year Communities Putting Prevention to Work (CPPW) grants, which were focused on “promoting wellness and health through programs that increased physical activity, improved nutrition, reduced obesity, and lowered tobacco use, among others.” Public Health – Seattle & King County received two CPPW grants; one for obesity prevention and one for tobacco prevention, with a combined total of $25 million.

When the ACA first passed in 2010, $15 billion was intended to be allocated the Fund over the first 10 years; the funding was deemed “mandatory.” However, law did allow for one important exception: “Congressional appropriations committees were allowed to tap money from the fund to spend on existing prevention or health proportion programs that met the goals of improving health and retaining growth in costs.” Unfortunately, due to federal budget constraints, in 2012 President Obama decided to cut the Fund by $5 billion over 10 years. Additionally, in 2013, the fund is facing an additional cut of $250 million.

To date, the most significant financial result of the Prevention and Public Health Fund has been the Community Transformation Grants (CTG) program, which “supports state- and community-level interventions to address the root causes of poor health.” The Washington State Department of Health (DOH) received a $3.2 million CTG award from the federal Centers for Disease Control and Prevention as part of the Affordable Care Act. Through a network of five hubs, the DOH CTG serves 36 counties in Washington state:

- **Central Washington**: Grays Harbor County Public Health and Social Services Department
- **Southwest**: Clark County Health Department
- **Northwest**: Whatcom County Health Department
- **Central**: Grant County Health Department
- **Eastern**: Spokane Regional Health District
Other CTG awardees in Washington state include: The Tacoma-Pierce County Health Department, Chehalis and Makah tribes, and Seattle Children’s Hospital. The specific amounts of the awards in Washington state are listed in Table 5.

Table 5. Community Transformation Grant (CTG) Awards in Washington State.

<table>
<thead>
<tr>
<th>ORGANIZATION</th>
<th>AMOUNT</th>
<th>POPULATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>WA Department of Health</td>
<td>$3,256,347</td>
<td>3,250,000 residents (excluding those in large counties, such as King County), including a rural population of over 800,000</td>
</tr>
<tr>
<td>Makah Tribe</td>
<td>$218,929</td>
<td>Planning award for a tribal population of 2,200</td>
</tr>
<tr>
<td>Chehalis Tribes</td>
<td>$498,663</td>
<td>Planning award for a tribal population of 1,500</td>
</tr>
<tr>
<td>Tacoma-Pierce County Health Dept</td>
<td>$796,836</td>
<td>814,000 residents</td>
</tr>
<tr>
<td>Seattle YMCA</td>
<td>$65,000</td>
<td>N/A</td>
</tr>
<tr>
<td>Seattle Children’s Hospital</td>
<td>$3,658,205</td>
<td>480,000 residents of South Seattle &amp; Seattle King County</td>
</tr>
<tr>
<td>Inland Northwest Health Services</td>
<td>$931,815</td>
<td>53,000 children living in six rural eastern Washington State counties</td>
</tr>
</tbody>
</table>


Seattle Children’s Hospital accepted the CTG grant with its key partners named in the grant, Public Health – Seattle & King County and the Healthy King County Coalition. This two-year Seattle-area award, named “Transforming the Health of South King County: Working with small communities to reduce regional health inequities,” was the third largest CTG grant awarded in the country. The Seattle-area grantees decided to focus their efforts on South Seattle and South King County neighborhoods because these areas are among the most racially diverse communities in the United States—these communities are also among the most significantly affected by health inequities in the United States (see Appendix E). Specifically, obesity impacts King County in the following manner:

- One in five youth in King County is overweight or obese.
- Rates are highest among males, youth of color and those in South King County.
- Children are at greater risk of being obese as adults and developing health disease, type 2 diabetes and other obesity-related illnesses.
- Adult obesity rates are 21% in King County and are estimated at 27% in the focus areas.

Additionally, tobacco use impacts King County in the following manner:

- In 2010, King County students who reported smoking cigarettes in the past 30 days included 4% of 8th graders, 9% of 10th graders and 15% of 12th graders,
- This translates to at least 10,000 middle and high school cigarette smokers.
Youth with the highest cigarette smoking rates are American Indian, Alaska Native, Native Hawaiian, Pacific Islander and Hispanic/Latino.

Seattle Children’s and its partners are leveraging their CTG grant by working “collaboratively with youth, families, and communities in South Seattle and South King County on nutrition, physical activity, and tobacco prevention, particularly among youth.”

Refer to Appendix J to more information on how the Fund was been allocated locally in 2011.

Future of the Fund

The Fund’s future appropriation levels are unknown. As of April, 2013, President Obama has proposed a FY 2014 budget include the “full $1 billion in allocations for the Prevention and Public Health Fund, as he recommends cancelling the sequester and implementing specific cuts and revenue increases instead.” However, great uncertainty remains regarding the financial future of the Prevention & Public Health Fund. Funding uncertainty is not new to the field of public health, and the Fund is no exception. Specifically, some of this uncertainty comes from the original design of the Fund; the funds are flexible (i.e., funds are not earmarked for any specific activity). While this flexibility is welcomes by state and local public health, the lack of earmarking, or categorizing, have made the “made the Prevention Fund a prime target for legislators looking to pay for other health-care activities.”

Figure 18 illustrates the rocky history of the Fund since it was created.

Figure 18. Prevention & Public Health Fund spending (in billions).

Accountable Care Communities (ACC)

ACC versus ACO

The Accountable Care Organization (ACO) model is becoming increasingly prominent in health care, and has been further promoted through the Affordable Care Act.\textsuperscript{60} Building on the ACO model, the Accountable Care Community (ACC) model encompasses not only medical care, but also broader public health system, community stakeholders, and community organizations.\textsuperscript{60,75} More directly, the focus of an ACC versus an ACO model is stated below:\textsuperscript{60,75}

- **ACO**: Focuses on defined and **targeted population of health consumers**; seeks to improve health outcomes and reduce total costs of care for a specified population by tying reimbursements to quality metrics that demonstrate improved outcome, rather than quantity metrics based on units of services provided (i.e., fee-for-service).

- **ACC**: Focuses on health **outcomes of the entire population** of a defined geographic region.

The ACC model goes one step further from the ACO model; it represents the realization that if the ACO model is able to “achieve reductions in the total cost of care for a designated population of patients,” then a “portion of those savings could potentially be set aside to invest in community-prevention initiatives aimed at improving community environments.”\textsuperscript{60}

**ACC model structural components:**\textsuperscript{75}

- Development of integrated medical and public health models to deliver clinical care in tandem with health promotion and disease prevention efforts;

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In February 2012, a deficit reduction package passed, resulting in $6.5 billion in cuts from the Prevention and Public Health Fund, leaving it with the budget seen in green above (Figure 18).\textsuperscript{74} The cut eliminated just over a third — 37 percent — of the Fund’s budget.\textsuperscript{74} The justification Congress provided for the cuts to the Fund was to use these funds as part of a package to keep Medicare provider payments stable.\textsuperscript{74}

“The diversion of funds is a disproportionately large burden. We should not be creating a competition between the potential gains from more people receiving insurance and more people taking part in preventive services.”

- Jeff Levi
  President, Trust for American’s Health

**ACCOUNTABLE CARE COMMUNITIES (ACC) DEFINITION**

“Collaborative, integrated, and measurable multi-institutional approach that emphasized shared responsibility for the health of the community, including health promotion and disease prevention, access to quality services, and health care delivery.”\textsuperscript{75}

**Ultimate goal:** A healthier community.
Utilization of inter-professional teams including, but not limited to, medicine, pharmacy, public health, nursing, social work, mental health, and nutrition to align care management and improve patient access and care coordination;

Collaboration among health systems and public health, to enhance communication and planning efforts;

Development of a robust health information technology infrastructure, to enable access to comprehensive, timely patient health information that facilitates the delivery of appropriate care and execution of effective care transitions across the continuum of providers;

Implementation of an integrated and fully mineable surveillance and data warehouse functionality, to monitor and report systematically and longitudinally on the health status of the community, measuring change over time and assessing the impact of various intervention strategies;

Development of a dissemination infrastructure to rapidly share best practices;

Design and execution of a robust ACC implementation platform, specific tactics, and impact measurement tool; and,

Policy analysis and advocacy to facilitate ACC success and sustainability.

**ACC measurement/evaluation components:**

- Community participation;
- Local, national, and regional burden of disease;
- IOM Specific Aims for 21st century health care;
- Primary, secondary and tertiary prevention indicators;
- Community intervention measures;
- Care coordination metrics;
- Determinants of health;
- Health information technology (HIT) utilization and information sharing metrics;
- Clinical improvement metrics;
- Patient safety metrics;
- Patient self-management measures; and,
- Patient-centered medical home measures.

**ACC overarching goals:**

- Optimize efficiency;
\begin{itemize}
\item Spend less than current levels or, at a minimum, have better outcomes at the current spending level; and,
\item Have a health care system that links with public health and social services for a coherent whole.
\end{itemize}

**Examples:**

\begin{itemize}
\item **Public Health – Seattle & King County (PHSKC), Washington** (Janna Wilson, Senior External Relations Officer, Public Health – Seattle & King County. Oral communication, 30 April 2013.

Hospitals and health systems across King County are working to incorporate the ACO model. While PHKSC is increasingly working to integrate with the delivery system, there is not a formal ACO/ACC including PSHKC. To date, two of the most notable areas where PHSKC is integrating includes partnering with hospital on the community health needs assessment requirement of the ACA, and the King County Health and Human Services proviso (more information on the proviso is detailed earlier in the report).

\item **Regional Health Network (RHA), Southwest Washington**

In southwest Washington a collaborative reminiscent of an ACC has formed, called the Regional Health Network (RHA). The RHA was inspired by a similar network that originated in Bend, Oregon. The network is composed of the following list of diverse stakeholders:76

- Clark County
- Cowlitz County
- Skamania County
- Wahkiakum County
- Regional Support Networks (RSNs)
- Cowlitz Tribe
- Commercial health plans

The overarching goal of the RHA is to empower “local communities to identify local needs and help redesign the delivery systems for the safety net,” with the help of the tools of the Affordable Care Act (ACA).76 Specifically, the RHA was developed as a new approach to the ACO model supported in the ACA, in addition to providers serving “Medicaid enrollees and other individuals and families in the safety net” in the southwest Washington region.76 The purpose of the RHA is to “organize the payers of care to create a supportive payment, structural, and regulatory environment along with a regional health information exchange that best facilitates clinical integration among the providers of safety net care.”76
More directly, the work of the RHA includes standardizing the payment models and performance measures across all payers, which include:

- Medicaid
- Washington state health exchange plans
- Counties
- Health departments
- State agencies
- Private funders, etc.

RHA’s highly collaborative nature provides a foundation for facilitating regional health planning across health delivery structures, reducing existing and future administrative burdens, and implementing new payment models. This foundation serves to “aid provider groups in achieving better health for the regional population, better care for individuals, and reduced cost through health status improvement - not rationing or fee reductions (the Triple Aim).”

- **Akron ACC, Summit County, Ohio**

  One of the country’s first ACC’s was formed in Summit County, Ohio, as a “collaborative of health providers, local government agencies, and community-based organizations,” with the goal of promoting wellness, and is led by the Austen BioInnovation Institute (ABIA). Participating health care providers cover “85 percent of the county’s half-million residents as well as a substantial population in surrounding counties that will also benefit from the ACC’s activity.” The Akron ACC represents an integration between medical and public health models, making use of teams composed of physicians, pharmacists, nurses, social workers, mental health professionals, and nutritionists.

  **Examples** of Akron ACC’s work to date include the following:

  - Underserved Akron neighborhood identified that has no public transportation access to a national park located just outside the city, Cuyahoga Valley National Park, and the recreational and physical activity opportunities it provides. The ACC worked with the local public transit agency to establish a new bus line connecting the community to the park.

  - The ACC is also partnering with the metropolitan housing authority and the city planning department to improve local housing, pedestrian and bicyclist infrastructure.
• Partnerships established with local employers of all sizes to set up worksite wellness initiatives.

The funding mechanism for the Akron ACC thus far has been through grants, including a Community Transformation Grant from the Centers for Disease Control and Prevention, and Community Benefit funds from local hospital systems. However, leaders of the Akron ACC effort “believe they have developed a model that will be financially self-sustaining in the long term.” They believe it will eventually be self-sustaining based off of the projection that “health care costs will be lowered by 10 percent as a result of the new programs and interventions;” a portion of the savings gets returned to the ACC, which is expected to cover all of the ACC’s operating costs and provide additional funds for future investment in the community.

- Community Care of North Carolina (CCNC) program

The CCNC program came from a growing awareness of rapidly increasing challenges in North Carolina’s Medicaid program. Specifically, the challenges related to “rising costs at both the individual beneficiary and population levels.” The response of the state to combat these challenges was the creation of a statewide medical home and managed care system.

**Overarching goal of the program:** Improve access to, quality of, and coordination of care while decreasing the cost to the Medicaid program in North Carolina.

**Finances:** The CCNC program is funded by a per-member-per-month (PMPM) reimbursement to the networks, in addition to fee-for-service and PMPM payments to the providers.

**Results (to date):**

- **HEDIS:** North Carolina now ranks in the top 10% in the nation in the Health Effectiveness Data and Information Set (HEDIS) measured for diabetes, asthma, and heart disease;

- **Medicaid program savings** of over $700 million since 2006 through CCNC initiatives;

- **Lower costs:** When adjusted for severity, costs are 7% lower than expected; and,

- **PMPM cost reductions:** 2011 PMPM costs for the Medicaid population are 6% lower than 2010.
A LOOK INTO THE FUTURE

At the end of the day, public health governance structure is only as strong as the level of funding that supports it; if resources are scarce, the strength of the public health governance structure is of negligible importance (Don Sloma, Director, Thurston County Public Health and Social Services. Oral Communication, February, 2013). In the 1990s and in the 2000s the Washington State Legislature acknowledged public health was underfunded, resulting in $20 million funding dedicated to public health. However, state funding for local public health has since been drastically cut, while at the same time the population continues to grow (Figure 19). The Great Recession has further compounded the downward trend in public health funding over the past decade.

Figure 19. Washington State total population.

![Graph showing population growth](http://www.ofm.wa.gov/pop/stfc/default.asp)

This rapid decline in public health funding threatens the functioning of crucial public programs, which in turn threaten the health and wellbeing of Washington state citizens. Furthermore, elected officials and the public at large have supported the shift from the small amount of prevention funding that once existed to health care organizations and social services (i.e., hospital care and the Department of Health Services). Don Sloma, Director of Thurston County Public Health and Social Services with decades of Washington state public health and policy expertise, believes that a “large part of the problem is the historical weakness of public health in communicating the value of prevention services to the broad community, and why state funding should support services with straightforward outcomes and deliverables to measure.”
FINAL RECOMMENDATIONS

Recommendation 1: Strengthen Washington state’s governmental public health infrastructure; continue move toward shared services and regionalization.

Governmental public health’s structural weaknesses are not new. A 1988 Institute of Medicine Report concluded that United States public health agencies are largely in disarray. More recently, the Centers for Disease Control and Prevention has come to the conclusion that despite recent improvements, the public health infrastructure “is still structurally weak in nearly every area.”

Washington state’s decentralized public health system allows for a substantial network of LHJs, which has “important benefits for the on-the-ground business of assessing and assuring the health and safety of local communities.” However, with 35 independent LHJs comes the potential for inefficiencies in the system. Specifically, in a large, decentralized system, there tend to be inefficiencies in “providing core services through what some have called a ‘patchwork’ of different entities with widely varying sizes, services, needs and priorities.”

A solution to some of the structural weaknesses that exist in Washington state is shared services or regionalization. Work to share services or regionalize, often in the form of multi-LHJ collaboration, is already underway in many parts of the state (see the Agenda for Change and Clark County example earlier in report). More of this work must be done, as a method of serving the public in a more effective, and cost-efficient manner.

Recommendation 2: Further define and fund LHJs core (foundational) public health services.

As Public Health – Seattle & King County Director and Health Officer, David Fleming, MD, notes, the first step in secure funding is effectively communicating what public health does (April, 2013). Unfortunately, public health has historically struggled to communicate what it does, and in turn, its value. To aid in more effectively communicating the value of public health, leaders across the state have worked to develop a common set of core public health services. It is recommended that Washington state’s LHJs should continue to work with the Department of Health to 1) finalize what the core public health services are, and 2) estimates for the cost of financing these core services.

Nationally, public health experts have recognized the need to better define the role of public health. In 1994, the United States Core Public Health Functions Steering Committee developed the 10 Essential Public Health Services for public health, which continue to provide a “working definition of public health and a guiding framework for the responsibilities of local public health systems.”
While the 10 Essential Services framework has been helpful over the past nearly 20 years, public health leaders have identified one important limitation: They are too broad and inclusive; in essence, the Essential Public Health Services framework indicates public health should be involved in every component of social well-being. To address this concern regarding the Essential Public Health Services, and in an effort specify the core public health services, Washington state’s Public Health Improvement Partnership (PHIP) has spent the last few years developing the “Agenda for Change,” which outlines what Washington state’s six foundational (or core) public health services should be (Figure 20).

Figure 20. Foundational Public Health Services

Additionally, according to David Fleming, MD, Public Health – Seattle & King County has developed three simple core public health services, called the 3Ps: 1) Provision; 2) Protection; and, Promotion (April, 2013).

**Recommendation 3:** Provide long-term and dedicated funding, equitable across the state.

A properly funded and governed public health system has the potential of providing the following to the community:

- Essential community health services;
- Saves individuals and communities from the suffering and disproportionate expense of preventable disease; and,
- Actively prepares for potentially devastating health threats.

“Stable and sufficient funding sources are essential to maintaining a sound public health system. All people in Washington need and expect a predictable level of public health services, regardless of current economic conditions.”

- Washington state’s Public Health Improvement Partnership (PHIP)
The public health system is a “long-term investment, made in the most effective and stable form when particular revenue sources can be dedicated to maintaining its core capacity.”\textsuperscript{3} When public health funding is unstable and unpredictable, as it have been in recent years across the nation, “effective management and planning becomes quite difficult.”\textsuperscript{3}

While an asset of local public health compared to state of federal public health is that “local public health services will always reflect the values and priorities of local communities.”\textsuperscript{3} However, in recent years, the “pattern of health protection across the state is marked by extreme disparities.”\textsuperscript{3} Not only is this disparity an equity issue, it is also an important issue when it comes to communicable diseases: “Diseases do not respect jurisdictional boundaries, and in the event of a broad threat to public health, a ‘weak link’ at one jurisdiction could put thousands at risk elsewhere in the state.”\textsuperscript{3} A possible solution to the disparities in LHJ funding that exists across the state is to revise the state-level formulas that are used to fund local public health; population-based formulas are more appropriate for large health departments, such as Public Health –Seattle & King County.

**Recommendation 4:** Washington state should explore new and innovative methods of sustainably funding local public health.

Washington state must look to the innovative efforts of Massachusetts and New York (see descriptions earlier in report), as well as promising public health funding solutions such as Health Impact Bonds. Washington state has been nationally recognized as being a public health leader for years, and there are many progressive, passionate public health leaders in this state. Washington state’s reputation, resources, and brain-power must be channeled into exploring ways of adopting some, if not all, of these emerging public health financing solutions that are underway in other parts of the country.

**Recommendation 5:** Public health must effectively communicate its value to society and strengthen community involvement.

David Fleming, MD, Director and Health Officer of Public Health – Seattle & King County believes that by more effectively communicating with the public, through avenues such as community organizations and the business community, securing a sustainable funding stream for public health will be easier to achieve (April, 2013). An effective way to communicate with the public is to engage them to actively participate in improving the health of their community. Local organizations, such as churches, civic organizations, and health advocacy groups, are “well placed to assess needs, inventory resources, formulate collaborative responses, and evaluate outcomes for community health improvements,” as well as “promote healthy behavior and lifestyles and can facilitate social networks.”\textsuperscript{78}
In addition, businesses play a “major role in the health of their employees and the population through their effects on natural and built environments, workplace conditions, and relationships with communities.” Community members and business leaders not only have a significant stake in the health of their community, they serve as powerful forces to aid public health in community its value to policymakers.

CONCLUSION

As illustrated by the examples in this report, there are numerous new and innovative opportunities for public health. With new public health leadership at the state level for the first time in 15 years, Washington state is poised to continue moving forward in a promising direction; perhaps with leadership that will continue to support and encourage bold new steps in creating and maintaining sustainable financing mechanisms for local public health.
REFLECTIONS

What worked well?
Many components of this process worked extremely well. Most importantly was the level of engagement from both of my advisers, Bud Nicola and Jennifer Muhm. They both served as excellent expert sources, connecters to other resources, and made themselves available to help with the process.

Additionally, the topic and focus of the report is extremely timely. As a result, this deliverable will be of great service to Public Health – Seattle & King County, as well as the public health community at large. Specifically, this report will serve as a tool for public health leaders and policymakers with an interest in working to strengthen Washington’s public health system, especially those struggling to find solutions to local public health funding deficiencies.

Further, numerous key public health leaders were extremely generous in lending their expertise, historical knowledge, and creative solutions to the public health funding quagmire. This report includes insight from many key public health leaders in Washington state, which is huge success in and of itself.

Finally, this process served as an excellent learning opportunity. Reflecting on the journey taken to arrive at the final report, all of the ins and outs of the history of public health governance and funding nationally, at the Washington state level, and locally have been touched on. The knowledge and the skill set developed throughout this process will prove invaluable.

What did not work well?

Early in the process, it was especially difficult to focus in on the narrow aim of the capstone. A way this could improve in the future would be to conduct a more extensive literature review and interview public health experts about the initial broad topic prior to narrowing in my focus.

The inclusiveness and sheer size of the topic chosen proved to be both a wonderful learning opportunity and (at times) an overwhelming feat to conquer. Essentially, the goal overarching aim of the report was to form key recommendations to help “fix” the public health financing problem (the million-dollar question). In the beginning of the capstone process, the sheer size of this task may not have been entirely understood.
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APPENDICES

Appendix A. Revised Code of Washington (RCW) 70.05.040 or 70.05.035

The local health officer, acting under the direction of the local board of health or under direction of the administrative officer is appointed under Revised Code of Washington (RCW) 70.05.040 or 70.05.035:36

1. Enforce the public health statutes of the state, rules of the state board of health and the secretary of health, and all local health rules, regulations and ordinances within his or her jurisdiction including imposition of penalties authorized under RCW 70.119A.030 and 70.118.130, the confidentiality provisions in RCW 70.24.105 and rules adopted to implement those provisions, and filing of actions authorized by RCW 43.70.190;

2. Take such action as is necessary to maintain health and sanitation supervision over the territory within his or her jurisdiction;

3. Control and prevent the spread of any dangerous, contagious or infectious diseases that may occur within his or her jurisdiction;

4. Inform the public as to the causes, nature, and prevention of disease and disability and the preservation, promotion and improvement of health within his or her jurisdiction;

5. Prevent, control or abate nuisances which are detrimental to the public health;

6. Attend all conferences called by the secretary of health or his or her authorized representative;

7. Collect such fees as are established by the state board of health or the local board of health for the issuance or renewal of licenses or permits or such other fees as may be authorized by law or by the rules of the state board of health;

8. Inspect, as necessary, expansion or modification of existing public water systems, and the construction of new public water systems, to assure that the expansion, modification, or construction conforms to system design and plans;

9. Take such measures as he or she deems necessary in order to promote the public health, to participate in the establishment of health educational or training activities, and to authorize the attendance of employees of the local health department or individuals engaged in community health programs related to or part of the programs of the local health department.
Appendix B: Public Health Service Standards, Improvement Plan, and Indicators.

The 1993 Health Services Act required the state department of health to develop a public health improvement plan for consideration by the 1995 legislature. The initial plan contained 88 capacity standards intended to measure state and local health jurisdictions' infrastructure adequacy and 29 health outcome measures. Among the plan's recommendations was that state and local health department contractual relations contain specific service delivery capacity objectives and health outcome objectives to be used as a basis for accountability.44

The Public Health Improvement Act of 1995 required that the state develop "performance-based contracts" with each local agency based on "the core functions of public health." Basic standards for public health are part of the biennial public health improvement plan. A single standard was proposed for the public health system, with separate state and local measures that demonstrate whether a standard is met. This set of standards is limited to the responsibilities of state and local government. The contributions of non-government health providers and community-based organizations are essential, but they are separate from the specific accountability expected of government agencies.44

Health Boards

The Health Services Act of 1993 restructured governance of health departments by transferring authority to counties and removing city representation from local boards of health, except by appointment.44

The local board of health is to:44

- Enforce through the local health officer or the administrative officer the public health statutes of the state and rules;
- Supervise the maintenance of all health and sanitary measures for the protection of the public health within its jurisdiction;
- Enact such local rules and regulations as are necessary in order to preserve, promote and improve the public health and provide for the enforcement thereof;
- Provide for the control and prevention of any dangerous, contagious or infectious disease within the jurisdiction of the local health department;
- Provide for the prevention, control and abatement of nuisances detrimental to the public health;
- Make such reports to the state board of health through the local health officer or the administrative officer as the state board of health may require; and,

- Establish fee schedules for issuing or renewing licenses or permits or for such other services as are authorized by the law and the rules of the state board of health: Fees for services cannot not exceed the actual cost of providing any such services.

Unless the county is part of a health district, the board of county commissioners constitutes the board of health in counties without a home rule charter. In counties with a home rule charter, the county legislative authority establishes the local board of health, and determines terms of office, compensation or reimbursement, and membership criteria. The county legislative authority may appoint elected officials from cities and towns and persons other than elected officials so long as persons other than elected officials do not constitute a majority.\textsuperscript{44}

**Health Officer**

Each local board of health must appoint a licensed, experienced physician who is qualified, or is provisionally qualified, in accordance with the standard prescribed in RCW 70.05.051. The local health officer is the executive secretary to, and administrative officer for the local board of health. See also RCW 70.46.090; a health department is not deemed to provide adequate public health service unless there is at least one full time professionally trained and qualified physician as set out in RCW 70.05.050.\textsuperscript{44}

**Health Departments and Health Districts**

**Combined City-County Health Department**

Any city with a population of 100,000 or more and the county in which it is located may form a combined city and county health department and appoint a director of public health. Any other city, other governmental agency, or any charitable health agency may contract with the agency to receive public health services.\textsuperscript{44}

- Seattle-King County Public Health
- Tacoma-Pierce County Health Department

**Health Departments**

- Adams County Health Department
- Clallam County Department of Health and Human Services
- Clark County Department of Public Health
- Cowlitz County Health Department
- Grays Harbor County Division of Environmental Health
- Island County Public Health
- Jefferson County Public Health
- Kittitas County Public Health Department
- Klickitat County Public Health
- Lewis County Public Health and Social Services
- Lincoln County Health Department
- Mason County Public Health
- Pacific County Public Health and Human Services Department
- San Juan County Health and Community Services
- Skagit County Public Health
- Skamania County Public Health
- Thurston County Public Health and Social Services
- Wahkiakum County Health and Human Services
- Walla Walla County Health Department
- Whatcom County Health Department
- Whitman County Department of Public Health

Health Districts

A health district is all the territory consisting of one or more counties organized pursuant to the provisions of Ch. 70.05 RCW and Ch. 70.46 RCW. The district board of health shall constitute the local board of health for all the territory included in the health district, and shall supersede and exercise all the powers and perform all the duties by law vested in the county board of health of any county included in the health district (RCW 70.46.060). The expense of providing public health services shall be borne by each county within the health district (RCW 70.46.085).

1. Asotin County Health District
2. Benton-Franklin Health District
3. Chelan-Douglas Health District
4. Garfield County Health District
5. Grant County Health District
6. Kitsap County Health District
7. Okanogan County Public Health
8. Snohomish Health District
9. Spokane Regional Health District
10. Northeast Tri County Health District - Ferry, Stevens, Pend Oreille County
11. Yakima Health District

Organizations and Agencies

- American Public Health Association (APHA)
- Association of State and Territorial Health Officials (ASTHO)
- **Centers for Disease Control and Prevention (CDC)**
- **Family Policy Council of Washington State**
- **Health Resources and Services Administration (HRSA)**
  - HRSA Region 10 Contacts
- **National Association of County and City Health Officials (NACCHO)**
  - Washington State Association of Local Public Health Officials
- **National Institutes of Health**
- **Northwest Center for Public Health Practice (NWCPHP)** - Provides training, research, evaluation, and communications services to support public health organizations. An outreach program of the University of Washington School of Public Health.
- **Partners in Information Access for Public Health Professionals** - A collaboration of U.S. government agencies, public health organizations and health sciences libraries
- **Public Health Foundation (PHF)** - The Public Health Foundation (PHF) is dedicated to achieving healthy communities through research, training, and technical assistance
- **United States Department of Health and Human Services**
- **Washington State Department of Health**
  - Data and Statistics
- **Washington State Department of Social and Health Services**
Appendix C: WSALPHO Strategic Direction 2011-2015

## Appendix D: Allocation of State Flexible Funds for Calendar Year 2011

<table>
<thead>
<tr>
<th>County</th>
<th>MVET Replacement Funds ($)</th>
<th>5930 County Public Health Assistance ($)</th>
<th>Local Capacity Development Fund ($)</th>
<th>TOTAL ($)</th>
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<td>134,649</td>
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<td>Lincoln</td>
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<td>Mason</td>
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<td>Northeast Tri-County</td>
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<td>1,235,964</td>
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<td>48,638</td>
<td>215,921</td>
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<td>579,689</td>
<td>261,357</td>
<td>266,732</td>
<td>1,107,778</td>
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<td>TOTAL</td>
<td>22,303,000</td>
<td>7,600,000</td>
<td>7,609,000</td>
<td>37,512,000</td>
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</tbody>
</table>

Adapted from: Washington State Department of Health, 2011
Appendix E. King County Population Health Disparities

Geographical variation in life expectancy in King County
Appendix F. Blue Ribbon Commission on Health Care Costs and Access Recommendations

1. **Use state purchasing to improve health care quality:** Change the way the state government pays for health care by rewarding care that measurably improves health and wellness.49

2. **Become a leader in the prevention and management of chronic illness:** The Commission recommends that state health purchasing agencies integrate proven chronic care management into all state programs, and require enrollees with chronic conditions to participate in such programs.49

3. **Provide cost and quality information for consumers and providers:** The Commission recommends that state health purchasing agencies will partner with the Puget Sound Health Alliance and other local organizations to develop a sound set of measures allowing consumers to compare provider cost and quality; develop Washington-specific information, and disseminate information on cost-effective treatment and best practices.49

4. **Deliver on the promise of health information technology:** The Commission recommends that the Health Information Infrastructure Advisory Board develop a system to provide electronic access to patient information from anywhere in the state.49

5. **Reduce unnecessary emergency room visits:** The Commission recommends that state health purchasing agencies partner with the Washington State Hospital Association, the Washington State Medical Association to measure and reduce unnecessary emergency room utilization.49

6. **Reduce health care administrative costs:** The Commission recommends that the Commission recommends that the Office of the Insurance Commissioner provide a report to the Governor and the Legislature that identifies the key contributors to health care administrative costs and evaluates opportunities to address them.49

7. **Support community organizations that promote cost-effective care:** The Commission recommends that the Health Care Authority evaluate the effectiveness of the Community Health Care Collaborative Grant Program in improving access to high-quality, efficient health care at the local level, and build upon identified successes.49

8. **Give individuals and families more choice in selecting private insurance plans that work for them:** The Commission recommends that by February 1, 2007, the Office of the Insurance Commissioner, in collaboration with in-state and out-of-state insurance carriers, state health purchasing agencies, consumers, business organizations and others, provide a report to the
9. **Partner with the federal government to improve coverage**: The Commission recommends that the state modify Medicaid and the Basic Health Program to assure their sustainability and cover as many people as possible within available funds; and, support federal legislation encouraging innovative state coverage strategies.\(^4^9\)

10. **Organize the insurance market to make it more accessible to consumers**: The Commission recommends that legislation be introduced that will, through a public/private partnership allow contributions of an employee and his or her employer(s) to be combined with a possible state subsidy to purchase insurance that neither the employee nor employer could afford on their own.\(^4^9\)

11. **Address the affordability of coverage for high-cost individuals**: The Commission recommends that by March 1, 2007, the Office of the Insurance Commissioner shall provide a report to the Governor and the Legislature evaluating options for restructuring and improving the Washington State Health Insurance Pool.\(^4^9\)

12. **Ensure the health of the next generation by linking insurance coverage with policies that improve children’s health**: Enroll all children eligible for state programs through improved outreach and marketing; allow parents to cover their children through SCHIP; use state purchasing to measurably improve children’s health; and, encourage parental responsibility.\(^4^9\)

13. **Initiate strategies to improve childhood nutrition and physical activity**: The Commission recommends the state promote strategies related to childhood nutrition, physical activity and the consequences of childhood obesity, considering options such as partnering with local public health and introducing legislation to encourage nutritious food options and physical activity for students in K-12 education.\(^4^9\)

14. **Pilot a health literacy program for parents and children**: The Commission recommends that the Health Care Authority partner with other state agencies and local organizations to implement a demonstration project that helps families make more informed decisions about their children’s health care.\(^4^9\)

15. **Strengthen the public health system**: The Commission recommends that the state, subject to appropriation, invest in public health funding strategies that are accountable for improved health outcomes, based on the recommendations of the Joint Select Committee on Public Health Financing.\(^4^9\)

16. **Integrate prevention and health promotion into state health programs**: The Commission recommends that by September 2007, the Department of Health, the Health Care Authority, the Department of Labor and Industries and the Health and Recovery Services Administration develop a strategic...
plan to: structure benefits and reimbursements in all state insurance programs to promote healthy choices and disease and accident prevention; require enrollees in the Basic Health Plan to complete a health assessment, and provide appropriate follow-up; reimburse cost-effective prevention activities within the Medicaid fee-for-service and the Uniform Medical Plan; develop prevention and health promotion contracting standards through the Public Employees Benefit Board (PEBB), the BHP and Medicaid Healthy Options; and, strengthen the state’s employee wellness program in partnership with the state’s Health & Productivity Committee.49
## Appendix G: State-level funding comparison

<table>
<thead>
<tr>
<th>State</th>
<th>Contact</th>
<th># of LHI*</th>
<th>% of Total Annual LHI Revenue*</th>
<th>STATE Funding Source for Local Health Department</th>
<th>Funding Source/ Mechanisms</th>
<th>Annual Amount (2012 Budget)</th>
<th>Categorical or Flexible</th>
<th>Rate of Increase/ Decline Since 2008</th>
<th>Date Funding Source Est.</th>
<th>Funding Authority</th>
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</thead>
<tbody>
<tr>
<td>CT</td>
<td>Connecticut Public Health Association Alyssa Norwood 860-727-9874, ext. 107 <a href="mailto:anorwood@cadh.org">anorwood@cadh.org</a></td>
<td>77</td>
<td>19%</td>
<td>State support for local public health General Fund – State</td>
<td>$4,000,000 - 5,000,000</td>
<td>Flexible</td>
<td>N/A</td>
<td>N/A</td>
<td>State leg</td>
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<td></td>
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<td>Tobacco (can be used for non-tobacco health programs though) Other state funds</td>
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<td>Categorical (can be flexible in reality)</td>
<td>N/A</td>
<td>N/A</td>
<td>State tobacco settlement money</td>
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<tr>
<td>FL</td>
<td>Kim Barnhill, Chief of Staff, Florida DOH, <a href="mailto:kim_barnhill@doh.state.fl.us">kim_barnhill@doh.state.fl.us</a></td>
<td>67</td>
<td>31%</td>
<td>Preparedness Grant Match General Fund – State</td>
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<td>Categorical</td>
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<td>School Health General Fund – State and Tobacco Funds</td>
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<td>Community Tuberculosis General Fund – State</td>
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<td>1997</td>
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<td>State</td>
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<td>% of Total Annual LHJ Revenue*</td>
<td>STATE Funding Source for Local Health Department</td>
<td>Funding Source/ Mechanisms</td>
<td>Annual Amount (2012 Budget)</td>
<td>Categorical or Flexible</td>
<td>Rate of Increase/ Decline Since 2008</td>
<td>Date Funding Source Est.</td>
<td>Funding Authority</td>
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<tr>
<td>MA</td>
<td>Massachusetts Public Health Association Maddie Ribble Director of Policy and Communications (857) 263-7072, ext. 111 <a href="mailto:mribble@mphaweb.org">mribble@mphaweb.org</a></td>
<td>330</td>
<td>7%</td>
<td>Tobacco Community Intervention</td>
<td>Other state funds</td>
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<td>-16%</td>
<td>1997</td>
<td>State Leg</td>
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<tr>
<td>MD</td>
<td>Ginny Seyler, M.H.S. Core Funding Program Coordinator and Local Health Liaison Health Systems and Infrastructure Administration Maryland Dept. Health &amp; Mental Hygiene 300 W. Preston St., Suite 410 Baltimore, MD 21201 Phone: 410-767-0902 Fax: 410-333-5995 Email: <a href="mailto:ginny.seyler@maryland.gov">ginny.seyler@maryland.gov</a></td>
<td>24</td>
<td>45%</td>
<td>State support for Core Public Health functions</td>
<td>State General funds</td>
<td>38,000,000</td>
<td>Flexible among 7 PH areas</td>
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<td>1950’s</td>
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<td>Family Planning</td>
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<tr>
<td>ME</td>
<td>Dennise Whitley, MHA Chief Policy Officer Maine Public Health Association 11 Parkwood Drive Augusta, Maine 04330 207.743.7541 (O) 207.461.3101 (Cell)</td>
<td>10</td>
<td>16%</td>
<td>Attorney General Tobacco Surveillance</td>
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<td>119,687</td>
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</table>

<table>
<thead>
<tr>
<th>State</th>
<th>Contact</th>
<th># of LHJ*</th>
<th>% of Total Annual LHJ Revenue*</th>
<th>STATE Funding Source for Local Health Department</th>
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<td>Massachusetts Public Health Association Maddie Ribble Director of Policy and Communications (857) 263-7072, ext. 111 <a href="mailto:mribble@mphaweb.org">mribble@mphaweb.org</a></td>
<td>330</td>
<td>7%</td>
<td>Tobacco Community Intervention</td>
<td>Other state funds</td>
<td>$7,500,000</td>
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<td>State Leg</td>
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<td>38,000,000</td>
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<td>-45%</td>
<td>1950’s</td>
<td>State Leg</td>
</tr>
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<td></td>
<td></td>
<td>Family Planning</td>
<td>State General Funds</td>
<td>5,500,000</td>
<td>Categorical</td>
<td>-19%</td>
<td>State Leg</td>
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<td></td>
<td></td>
<td></td>
<td>Improved Pregnancy Outcome</td>
<td>State General funds</td>
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<td></td>
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<td></td>
<td>Cancer outreach and diagnosis case mgmt</td>
<td>State General funds</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>TB/STD/HIV</td>
<td>State General funds</td>
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<td>Substance abuse services</td>
<td>State General Funds</td>
<td>35,732,558</td>
<td>Categorical</td>
<td>-27%</td>
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<tr>
<td>ME</td>
<td>Dennise Whitley, MHA Chief Policy Officer Maine Public Health Association 11 Parkwood Drive Augusta, Maine 04330 207.743.7541 (O) 207.461.3101 (Cell)</td>
<td>10</td>
<td>16%</td>
<td>Attorney General Tobacco Surveillance</td>
<td></td>
<td>119,687</td>
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<td>Substance abuse services</td>
<td>Fund for a Healthy Maine (FHM)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Health education centers</td>
<td></td>
<td>$1,100,353</td>
<td>Categorical</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Dental Education</td>
<td></td>
<td>237,740</td>
<td>Categorical</td>
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### Public Health Financing & Governance 2013

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<tr>
<th>State</th>
<th>Contact</th>
<th># of LHJ*</th>
<th>% of Total Annual LHJ Revenue*</th>
<th>STATE Funding Source for Local Health Department</th>
<th>Funding Source/Mechanisms</th>
<th>Annual Amount (2012 Budget)</th>
<th>Categorical or Flexible</th>
<th>Rate of Increase/Decline Since 2008</th>
<th>Date Funding Source Est.</th>
<th>Funding Authority</th>
</tr>
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<tbody>
<tr>
<td>MN</td>
<td>Allison Thrash, MPH</td>
<td>76</td>
<td>16%</td>
<td>300,000</td>
<td>Oral health</td>
<td>Categorical</td>
<td>1978</td>
<td>State Legislature</td>
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<td></td>
<td>Office of Performance Improvement Minnesota DOH</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>625 Robert St N, St. Paul, MN 55155 Mailing: PO Box 64975, St. Paul, MN 55164-0975 Phone: 651-201-3864</td>
<td></td>
<td></td>
<td></td>
<td>Family Planning</td>
<td>Defunded</td>
<td>Flat</td>
<td>1978</td>
<td></td>
<td>State Leg</td>
</tr>
<tr>
<td></td>
<td>Fax: 651-201-5099 E-mail: <a href="mailto:allison.thrash@state.mn.us">allison.thrash@state.mn.us</a> <a href="http://www.health.state.mn.us/divs/cfh/ophp">http://www.health.state.mn.us/divs/cfh/ophp</a></td>
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<td>Donated Dental</td>
<td>1,364,315</td>
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<td>2010</td>
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<td>Public health infrastructure</td>
<td>1,161,647</td>
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<td>Local Public Health Act Grant</td>
<td>State General Fund</td>
<td>$20,771,000 CY 2013 allocation</td>
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<td>Statewide Health Improvement Program (SHIP) Health Care Access Fund</td>
<td>State FY 2012/13 allocation</td>
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<td>No funding in 2008</td>
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<td>“Other state funds” Various</td>
<td>$29.5 million CY 2011 expenditures</td>
<td>Categorical</td>
<td>Various</td>
<td>Varies</td>
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<td>MT</td>
<td>Jane Smillie, Dale McBride</td>
<td>50</td>
<td>4%</td>
<td>104,000</td>
<td>TDAP Vaccine</td>
<td>State General Fund</td>
<td>$104,000</td>
<td>For TDAP Vaccine Only</td>
<td>0</td>
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<td># of LHJ*</td>
<td>% of Total Annual LHJ Revenue*</td>
<td>STATE Funding Source for Local Health Department</td>
<td>Funding Source/ Mechanisms</td>
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<td>Categorical or Flexible</td>
<td>Rate of Increase/ Decline Since 2008</td>
<td>Date Funding Source Est.</td>
<td>Funding Authority</td>
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<tr>
<td>OR</td>
<td>Morgan Cowling, Oregon Coalition of Local Health Officials; 503.329.6923</td>
<td>34</td>
<td>16%</td>
<td>State Support for Public Health</td>
<td>General Fund – State</td>
<td>$4,300,000</td>
<td>Must assure communicable disease needs are met and then can be flexible</td>
<td>0</td>
<td>2003 approx.</td>
<td>State Leg</td>
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<tr>
<td></td>
<td><a href="mailto:lwier@3rivers.net">lwier@3rivers.net</a>; <a href="mailto:dmcbride@mt.gov">dmcbride@mt.gov</a></td>
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<td>Child Adolescent &amp; Community Health</td>
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<td>$77,652</td>
<td>Children With Special Health Needs</td>
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<td>State General Fund &amp; State Special Revenue</td>
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<td>Public Health Inspections</td>
<td>Flat</td>
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<td>Public Health Home Visiting Program</td>
<td>State General Fund and State Special Revenue</td>
<td>$446,649</td>
<td>Public Home Visits</td>
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<td>Family Planning</td>
<td>State General Fund</td>
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<td>Family Planning Services</td>
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<td>State Leg</td>
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<td></td>
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<td>Chronic Disease Prevention</td>
<td>State Special Revenue from the Tobacco Master Settlement</td>
<td>$1,366,725</td>
<td>Cardiovascular &amp; Diabetes Disease Prevention and Asthma Program</td>
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<td>2000</td>
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<td>Tobacco Prevention</td>
<td>State Special Revenue from the Tobacco Master Settlement</td>
<td>$2,639,001</td>
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<td>Tribal Tobacco Prevention</td>
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<td>Vaccine Program</td>
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<tr>
<td>State</td>
<td>Contact</td>
<td># of LHJ*</td>
<td>% of Total Annual LHJ Revenue*</td>
<td>STATE Funding Source for Local Health Department</td>
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<td>Rate of Increase/Decline Since 2008</td>
<td>Date Funding Source Est.</td>
<td>Funding Authority</td>
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<tr>
<td></td>
<td>School Based Health Centers</td>
<td>General Fund and Other Funds- State</td>
<td>$2,500,000</td>
<td>Categorical</td>
<td>Flat</td>
<td>?</td>
<td>State Leg</td>
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<tr>
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<td>Babies 1st</td>
<td>General Fund- State</td>
<td>$500,000</td>
<td>Categorical</td>
<td>Flat</td>
<td>?</td>
<td>State Leg</td>
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<tr>
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<td>Immunizations</td>
<td>General Fund – State</td>
<td>$750,000</td>
<td>Categorical</td>
<td>Flat</td>
<td>?</td>
<td>State Leg</td>
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<td>Family Planning</td>
<td>General Fund and Other Funds – State</td>
<td>$2,500,000</td>
<td>Categorical</td>
<td>Flat</td>
<td>?</td>
<td>State Leg</td>
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<tr>
<td>WA</td>
<td>Jennifer Muhm, Legislative Affairs Director, Public Health – Seattle &amp; King County</td>
<td>35</td>
<td>17%</td>
<td>MVET Backfill</td>
<td>General Fund – State</td>
<td>$40,000,000</td>
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<td>2001 (?)</td>
<td>State Leg</td>
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<tr>
<td></td>
<td>5930</td>
<td>General Fund – State</td>
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<td>Flexible</td>
<td>-50%</td>
<td>2006</td>
<td>State Leg</td>
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<td></td>
<td>Local Capacity Fund Development</td>
<td>General Fund – State</td>
<td></td>
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## Appendix H: Washington state county level funding comparison

<table>
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<tr>
<th>LHJ</th>
<th>Health District/Multi-County/County Department</th>
<th>County/Counties</th>
<th>Local Funding Source(s)/Mechanism</th>
<th>Amount (2012 Budget)</th>
<th>Rate of Increase/Decline Since 2008</th>
<th>Date Funding Source Established</th>
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<tr>
<td>Adams County Health Department</td>
<td>County Department</td>
<td>Adams</td>
<td>County General Fund</td>
<td>$52,432</td>
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<tr>
<td>Benton County</td>
<td>Multi-County Health District</td>
<td>Benton County</td>
<td>Benton County - $443,451</td>
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<td>Clark County Public Health</td>
<td>County Department</td>
<td>Clark</td>
<td>County General Fund</td>
<td>$2,255,845</td>
<td>55%</td>
<td>2003</td>
<td>County Commissioners</td>
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<tr>
<td>Chelan-Douglas Health District</td>
<td>Multi-County Health District</td>
<td>Chelan and Douglas Counties</td>
<td>Chelan County</td>
<td>$311,093</td>
<td>0%</td>
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<td>Douglas County</td>
<td>$146,726</td>
<td>0%</td>
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<td>Clallam County Department</td>
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<td>Clallam</td>
<td>County General Fund</td>
<td>$510,000</td>
<td>4%</td>
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<td>Department of Human Services</td>
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<td>Columbia County</td>
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<td>Columbia</td>
<td>Columbia</td>
<td>$380,698</td>
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<td>Franklin County</td>
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<td>Grant County Health District</td>
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<td>$1,380</td>
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<td>City of Royal City</td>
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<td>200%</td>
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<td>City of Krupp</td>
<td>$96</td>
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<td></td>
<td>City of Hartline</td>
<td>-</td>
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<td>City Council</td>
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<td></td>
<td></td>
<td>City of Grand Coulee</td>
<td>-</td>
<td>-100%</td>
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<td>City Council</td>
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<td>City of Ephrata</td>
<td>$11,535</td>
<td>11%</td>
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<td>City of Electric City</td>
<td>$1,000</td>
<td>0%</td>
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<td>-20%</td>
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<td>City of Wilson Creek</td>
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<td>4%</td>
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<td>Grays Harbor Public Health &amp;</td>
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<td>Grays Harbor</td>
<td>County General Fund</td>
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<td>LHJ</td>
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<td>County/Counties</td>
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<td>Funding Authority</td>
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<td>Jefferson County Public Health</td>
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<td>-26.92%</td>
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<td>County General Fund - Substance Abuse</td>
<td>$ -</td>
<td>-100.00%</td>
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<td>Substance Abuse Prevention Special Purpose Tax</td>
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<td>Health Nurse Special Purpose Tax</td>
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<td></td>
<td>Real &amp; Personal Property Taxes</td>
<td>$40,537.32</td>
<td>8.42%</td>
<td>N/A</td>
<td>Vote</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Private Harvest Tax</td>
<td>$1,635.65</td>
<td>-10.98%</td>
<td>N/A</td>
<td>Vote</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Leasehold Tax</td>
<td>$322.84</td>
<td>-11.20%</td>
<td>N/A</td>
<td>Vote</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Timber Sales</td>
<td>$1,121.09</td>
<td>-35.90%</td>
<td>N/A</td>
<td>Vote</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mental Health/Chemical Dependancy Sales Tax</td>
<td>$78,588.43</td>
<td>41.69%</td>
<td>2007</td>
<td>Vote</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>UGN / Private Donation</td>
<td>$4,131.45</td>
<td>-72.71%</td>
<td>N/A</td>
<td>Donation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>School District Payments</td>
<td>$32,538.04</td>
<td>9.71%</td>
<td>1992</td>
<td>Vote</td>
</tr>
<tr>
<td>Kitsap Public Health District</td>
<td>Health District</td>
<td>Kitsap</td>
<td>County General Fund</td>
<td>$1,262,556</td>
<td>-16%</td>
<td>1942</td>
<td>County Commissioners</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>City of Bainbridge Island</td>
<td>$49,518</td>
<td>3%</td>
<td>1955</td>
<td>City Council</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>City of Bremerton</td>
<td>$49,009</td>
<td>3%</td>
<td>1942</td>
<td>City Council</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>City of Port Orchard</td>
<td>$10,943</td>
<td>3%</td>
<td>1955</td>
<td>City Council</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>City of Poulsbo</td>
<td>$11,779</td>
<td>3%</td>
<td>1955</td>
<td>City Council</td>
</tr>
<tr>
<td>Kittitas County</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Klickitat Co. Health Department</td>
<td>Department</td>
<td>Klickitat</td>
<td>County General Fund</td>
<td>$200,000</td>
<td>-5%</td>
<td>1998</td>
<td>County Commissioners</td>
</tr>
<tr>
<td>Lewis County</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Lincoln County Health Department</td>
<td>County Department</td>
<td>Lincoln</td>
<td>County General Fund</td>
<td>$81,000</td>
<td>-10%</td>
<td>1970’s</td>
<td>County Commissioners</td>
</tr>
<tr>
<td>Mason County Health Department</td>
<td>County Department</td>
<td>Mason</td>
<td>County General Fund</td>
<td>$441,688</td>
<td>-57%</td>
<td>N/A</td>
<td>County Commissioners</td>
</tr>
<tr>
<td>Northwest Tri-counties health district</td>
<td>Health District</td>
<td>Ferry/Stevens/Pend Oreille</td>
<td>County General Fund</td>
<td>$856,866</td>
<td>14%</td>
<td>1977</td>
<td>County Commissioners</td>
</tr>
<tr>
<td>Okanogan County Public Health</td>
<td>Health District</td>
<td>Okanogan</td>
<td>County General Fund</td>
<td>$125,000</td>
<td>0%</td>
<td>1986</td>
<td>County Commissioners</td>
</tr>
<tr>
<td>LHJ</td>
<td>Health District/Multi-County/County Department</td>
<td>County/Counties</td>
<td>Local Funding Source(s)/Mechanism</td>
<td>Amount (2012 Budget)</td>
<td>Rate of Increase/Decline Since 2008</td>
<td>Date Funding Source Established</td>
<td>Funding Authority</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----------------------------------------------</td>
<td>----------------</td>
<td>-----------------------------------</td>
<td>----------------------</td>
<td>------------------------------------</td>
<td>-------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Pacific County</td>
<td>Local Health Jurisdiction</td>
<td>Pacific</td>
<td>County General Fund</td>
<td>$79,338</td>
<td>0%</td>
<td>Separated from Grays Harbor sometime in the early 1970’s</td>
<td>County Commissioners</td>
</tr>
<tr>
<td>Public Health - Seattle &amp; King County</td>
<td>County Department</td>
<td>King</td>
<td>County General Fund</td>
<td>$21,538,528</td>
<td>-8%</td>
<td>1951</td>
<td>County Council</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>City of Seattle</td>
<td>$14,977,786</td>
<td>10%</td>
<td>2005</td>
<td>City Council / County Council</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Vets &amp; Human Services Levy</td>
<td>$1,643,000</td>
<td>167%</td>
<td>2008</td>
<td>County Council / Vote of People</td>
</tr>
<tr>
<td>San Juan County</td>
<td>County Department</td>
<td>San Juan</td>
<td>“local revenue,” including “General Taxes, Special Revenues (e.g. Mental Health Tax, Affordable Housing fees) and other fees (septic permits, food permits, etc.). The only new funding source is the Mental Health Tax, passed December 2009.</td>
<td>$4,468,140</td>
<td>143%</td>
<td>N/A</td>
<td>County Council</td>
</tr>
<tr>
<td>Skagit County</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Skamania County</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Snohomish County</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Spokane Regional Health District</td>
<td>Health District</td>
<td>Spokane</td>
<td>Spokane County</td>
<td>$2,723,307</td>
<td>7%</td>
<td>1975</td>
<td>County council vote</td>
</tr>
<tr>
<td>Tacoma-Pierce County Health Department</td>
<td>Health District</td>
<td>Pierce</td>
<td>County General Fund</td>
<td>$2,424,790</td>
<td>-16%</td>
<td>1971</td>
<td>County Council</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>City General Fund</td>
<td>$555,790</td>
<td>0%</td>
<td>1971</td>
<td>City Council</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>County Department Grants</td>
<td>$916,230</td>
<td>-35%</td>
<td>1971</td>
<td>County Department / Council</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>City Department Grants</td>
<td>$774,210</td>
<td>-26%</td>
<td>1971</td>
<td>City Department / Council</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>City of Lakewood</td>
<td>$</td>
<td>-100%</td>
<td>2007</td>
<td>City Department / Council</td>
</tr>
<tr>
<td>Thurston County Public Health</td>
<td>County Department</td>
<td>Thurston</td>
<td>County General Fund</td>
<td>$1,207,529</td>
<td>-15%</td>
<td>1979</td>
<td>County Commissioners</td>
</tr>
<tr>
<td>Wahkiakum County</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>LHJ</td>
<td>Health District/Multi-County/County Department</td>
<td>County/Counties</td>
<td>Local Funding Source(s)/Mechanism</td>
<td>Amount (2012 Budget)</td>
<td>Rate of Increase/Decline Since 2008</td>
<td>Date Funding Source Established</td>
<td>Funding Authority</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------------------------------------</td>
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<td>-------------------------------------</td>
<td>-------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Walla Walla County</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whatcom County</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whitman County</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yakima County</td>
<td>Health District</td>
<td>Yakima</td>
<td>County General Fund</td>
<td>$4,048,336</td>
<td>-47%</td>
<td>1911</td>
<td>County Commissioners</td>
</tr>
</tbody>
</table>
### Appendix I: Public Health Services - Funding by LHJ by Revenue Source, 2011

<table>
<thead>
<tr>
<th></th>
<th>Federal through DOH</th>
<th>Federal from Other</th>
<th>Medicaid Title XIX &amp; Other Federal Fee-for-Service</th>
<th>Local Gov't Contrib.</th>
<th>Licenses, Permits &amp; Fees</th>
<th>Misc/Fund Balance/Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams</td>
<td>242,051</td>
<td></td>
<td>61,344</td>
<td>68,955</td>
<td>115,008</td>
<td>2,606</td>
</tr>
<tr>
<td>Asotin</td>
<td>356,541</td>
<td>153,561</td>
<td></td>
<td>68,450</td>
<td>156,997</td>
<td>12,402</td>
</tr>
<tr>
<td>Benton-Franklin</td>
<td>1,291,626</td>
<td>998,617</td>
<td>206,391</td>
<td>765,255</td>
<td>2,095,114</td>
<td>84,372</td>
</tr>
<tr>
<td>Chelan-Douglas</td>
<td>725,039</td>
<td>254,935</td>
<td>12,415</td>
<td>468,316</td>
<td>1,043,350</td>
<td>5,085</td>
</tr>
<tr>
<td>Clallam</td>
<td>527,392</td>
<td>112,498</td>
<td></td>
<td>737,550</td>
<td>593,419</td>
<td>40,163</td>
</tr>
<tr>
<td>Clark</td>
<td>1,781,521</td>
<td>677,404</td>
<td>101,701</td>
<td>2,228,365</td>
<td>2,663,772</td>
<td>314,385</td>
</tr>
<tr>
<td>Columbia</td>
<td>116,245</td>
<td>32,428</td>
<td>13,778</td>
<td>35,000</td>
<td>23,653</td>
<td>2,184</td>
</tr>
<tr>
<td>Cowlitz</td>
<td>442,052</td>
<td>170,263</td>
<td>10,452</td>
<td>563,598</td>
<td>458,233</td>
<td>56,583</td>
</tr>
<tr>
<td>Garfield</td>
<td>130,690</td>
<td>21,153</td>
<td>2,655</td>
<td>32,503</td>
<td>10,702</td>
<td>5,213</td>
</tr>
<tr>
<td>Grant</td>
<td>374,607</td>
<td>46,922</td>
<td>12,350</td>
<td>236,829</td>
<td>588,578</td>
<td>38,299</td>
</tr>
<tr>
<td>Grays Harbor</td>
<td>210,216</td>
<td>322,755</td>
<td></td>
<td>481,957</td>
<td>538,866</td>
<td>223,560</td>
</tr>
<tr>
<td>Island</td>
<td>494,906</td>
<td>399,194</td>
<td>3,912</td>
<td>221,406</td>
<td>859,625</td>
<td>7,500</td>
</tr>
<tr>
<td>Jefferson</td>
<td>391,314</td>
<td>193,378</td>
<td></td>
<td>1,012,320</td>
<td>1,057,040</td>
<td>19,009</td>
</tr>
<tr>
<td>Kitsap</td>
<td>1,211,775</td>
<td>669,952</td>
<td>192,704</td>
<td>3,061,157</td>
<td>2,293,314</td>
<td>75,344</td>
</tr>
<tr>
<td>Kittitas</td>
<td>174,640</td>
<td>78,813</td>
<td>4,048</td>
<td>85,632</td>
<td>369,221</td>
<td>133,693</td>
</tr>
<tr>
<td>Klickitat</td>
<td>251,179</td>
<td>175,905</td>
<td></td>
<td>482,033</td>
<td>205,587</td>
<td>29,322</td>
</tr>
<tr>
<td>Lewis</td>
<td>842,116</td>
<td>656,766</td>
<td>12,244</td>
<td>476,290</td>
<td>824,256</td>
<td>134,484</td>
</tr>
<tr>
<td>Lincoln</td>
<td>192,338</td>
<td>28,933</td>
<td>57,823</td>
<td>77,112</td>
<td>62,183</td>
<td></td>
</tr>
<tr>
<td>Mason</td>
<td>299,712</td>
<td>244,991</td>
<td>34,800</td>
<td>418,886</td>
<td>658,907</td>
<td>27,661</td>
</tr>
<tr>
<td>Northeast Tri-</td>
<td>536,366</td>
<td>127,038</td>
<td>179,282</td>
<td>836,395</td>
<td>261,365</td>
<td>41,337</td>
</tr>
<tr>
<td>County</td>
<td>117,008</td>
<td>7,487</td>
<td>125,000</td>
<td>399,044</td>
<td>16,274</td>
<td></td>
</tr>
<tr>
<td>Okanogan</td>
<td>427,186</td>
<td>68,530</td>
<td>52,344</td>
<td>141,397</td>
<td>20,896</td>
<td>1,804</td>
</tr>
<tr>
<td>Pacific</td>
<td>177,521</td>
<td>328,531</td>
<td></td>
<td>973,470</td>
<td>326,023</td>
<td>85,003</td>
</tr>
<tr>
<td>San Juan</td>
<td>20,896</td>
<td>7,487</td>
<td>23,653</td>
<td>68,450</td>
<td>2,968</td>
<td>7,500</td>
</tr>
<tr>
<td>Seattle-King County</td>
<td>20,520,329</td>
<td>40,834,939</td>
<td>32,530,527</td>
<td>44,132,058</td>
<td>30,783,867</td>
<td>6,574,375</td>
</tr>
<tr>
<td>Skagit</td>
<td>411,517</td>
<td>192,824</td>
<td>123,229</td>
<td>1,401,712</td>
<td>1,175,996</td>
<td>(10,099)</td>
</tr>
<tr>
<td>Skamania</td>
<td>192,063</td>
<td>411,157</td>
<td></td>
<td>825,504</td>
<td>151,605</td>
<td>211,943</td>
</tr>
<tr>
<td>Snohomish</td>
<td>2,133,773</td>
<td>524,042</td>
<td>2,714,802</td>
<td>4,638,140</td>
<td>79,994</td>
<td></td>
</tr>
<tr>
<td>Spokane</td>
<td>4,396,802</td>
<td>2,765,331</td>
<td>787,165</td>
<td>4,204,701</td>
<td>4,578,443</td>
<td>615,445</td>
</tr>
<tr>
<td>Tacoma-Pierce County</td>
<td>5,484,792</td>
<td>1,917,748</td>
<td>1,917,748</td>
<td>4,898,114</td>
<td>7,571,782</td>
<td>1,191,478</td>
</tr>
<tr>
<td>Thurston</td>
<td>517,377</td>
<td>302,531</td>
<td>52,351</td>
<td>1,347,244</td>
<td>3,244,181</td>
<td>312,633</td>
</tr>
<tr>
<td>Wahkiakum</td>
<td>318,101</td>
<td>158,586</td>
<td></td>
<td>69,052</td>
<td>35,594</td>
<td>2,968</td>
</tr>
<tr>
<td>Walla Walla</td>
<td>404,282</td>
<td>25,972</td>
<td>21,912</td>
<td>414,816</td>
<td>587,213</td>
<td>39,573</td>
</tr>
<tr>
<td>Whatcom</td>
<td>702,843</td>
<td>34,815</td>
<td>5,204,129</td>
<td>2,708,675</td>
<td>47,691</td>
<td></td>
</tr>
<tr>
<td>Whitman</td>
<td>299,973</td>
<td>2,500</td>
<td>20,498</td>
<td>399</td>
<td>281,825</td>
<td>54,227</td>
</tr>
<tr>
<td>Yakima</td>
<td>236,515</td>
<td>1,014,041</td>
<td>78,937,780</td>
<td>72,411,264</td>
<td>10,832,766</td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>47,771,283</td>
<td>2,836,536</td>
<td>5,204,129</td>
<td>4,898,114</td>
<td>7,571,782</td>
<td>1,191,478</td>
</tr>
</tbody>
</table>

Adapted from: Washington State Department of Health, 2011
### Appendix J: Federal Funding Allocations of the Prevention and Public Health Fund, Fiscal Year 2011.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Amount</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COMMUNITY PREVENTION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community and state prevention</td>
<td>$222 million</td>
<td>Implement Community Transformation Grants to support state and community initiatives to prevent heart disease, cancer, and other conditions by reducing tobacco use, preventing obesity, and reducing health disparities</td>
</tr>
<tr>
<td>Tobacco prevention</td>
<td>$60 million</td>
<td>Implement anti-tobacco media campaigns, telephone-based cessation services, and similar programs</td>
</tr>
<tr>
<td>Obesity prevention and fitness</td>
<td>$16 million</td>
<td>Advance activities to improve nutrition and increase physical activity</td>
</tr>
<tr>
<td><strong>CLINICAL PREVENTION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to wellness and preventive health services</td>
<td>$112 million</td>
<td>Increase awareness of preventive benefits under ACA; expand immunization services; strengthen employer wellness programs</td>
</tr>
<tr>
<td>Behavioral health screening and integration with primary health</td>
<td>$70 million</td>
<td>Help communities coordinate and integrate primary care services into public mental health and other community-based behavioral health settings; expand suicide prevention efforts and substance use disorders</td>
</tr>
<tr>
<td><strong>INFRASTRUCTURE AND TRAINING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public health infrastructure</td>
<td>$40 million</td>
<td>Support state, local, and tribal infrastructures to promote health and prevent disease through information technology, and workforce training</td>
</tr>
<tr>
<td>Public health workforce</td>
<td>$45 million</td>
<td>Support training of public health providers for preventive medicine, health promotion and disease prevention, and epidemiology; improve access to and quality of services in underserved communities</td>
</tr>
<tr>
<td>Public health capacity</td>
<td>$52 million</td>
<td>Build state and local capacity to prevent, detect, and respond to infectious disease outbreaks through improved epidemiology and lab capacity; invest in programs to prevent health care–associated infections</td>
</tr>
<tr>
<td><strong>RESEARCH AND TRACKING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surveillance and planning</td>
<td>$84 million</td>
<td>Fund data collection and analysis to monitor impact of ACA on health; increase collection of environmental hazards data</td>
</tr>
<tr>
<td>Prevention research</td>
<td>$49 million</td>
<td>Identify and disseminate evidence-based recommendations on public health challenges to practitioners, educators, and decision makers; expand development of recommendations for clinical preventive services</td>
</tr>
</tbody>
</table>

**Source:** Department of Health and Human Services, “Building Healthier Communities by Investing in Prevention,” Fact sheet posted February 9, 2011.

**Note:** ACA is Affordable Care Act of 2010.